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ABSTRACT

Focusing on issues concerning trust relationships within the nursing field, the papers in these proceedings consider relationships between nursing service and nursing education, staff or faculty and nursing administration, rural and urban nursing agencies, and among intercultural nursing groups. The proceedings contain: (1) "Trust: An Idealistic or Realistic Goal?" by Leah L. Curtin; (2) "Dynamics of Trust in Professional Relationships," by Angela B. McBride; (3) "Rewards and Risks of Trust Relationships," by Mary Fuller; (4) "Hospital-Community Nursing Service Relationships," by Ellen Elsbury; (5) "Nursing Staff Organization--Format for Building Trust," by Margretha Rohlfing; (6) "Trust Relationships in Academic Settings," by Mary Wakefield-Fisher; (7) "Cultural Dimensions of Trust," by Madonna Beard; and (8) caucus group discussion reports on trust relationships between staff or faculty and their nursing administrators, between service and education related to the conduct of clinical research, between rural and urban health care institutions, between nursing students and faculty, and trust relationships related to joint appointments. (AYC)

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Building Trust Relationships in Nursing

Midwest Alliance in Nursing

Program Meeting

April 1983

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BUILDING TRUST RELATIONSHIPS IN NURSING

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BUILDING TRUST RELATIONSHIPS IN NURSING

Preface

The members of the Midwest Alliance in Nursing indicated by survey in 1980 that the first priority of the organization should be to enhance the collaborative activities of nurses in nursing service and nursing education. The program committee of MAIN was directed by this mandate in the planning of programs.

The decision to hold a regional program focused on issues of trust relationships within nursing was proposed by the members of MAIN's Program Committee in 1982. This action received enthusiastic support from MAIN's Governing Board. The dimensions of trust to be included were relationships between nursing service and nursing education, staff or faculty and nursing administration, rural and urban nursing agencies, and among intercultural nursing groups.

This publication presents the creative thoughts and work of nurses as they responded to the following objectives of the conferences:

1. recognize behavioral and attitudinal signs of mistrust among nurses and nurse groups.

2. identify conditions leading to the development of mistrust among nurses and nurse groups.

3. identify professional and organizational problems which result from mistrust.

4. describe managerial and behavioral techniques in work settings that will build trust among nurses and nurse groups.

A basic element during the first year of life in human development is learning to trust. An infant is almost totally dependent on others to satisfy needs. This provides the opportunity for an infant to develop trusting relationships. This is learning which forms the basis for interpersonal relationships that span the decades of the infant's future life.

Nurses bring their previous learning experiences about trust with them into the profession. Unfortunately, in many instances that trust is betrayed by lack of agreement among nurses, petty bickering, semantic tumult, and

inconsistent beliefs about the purposes and goals of the profession.

Those of us who attended this meeting will long remember and savor the positive climate which was generated by the presentations. With tears of joy a participant stated "this program was a time of healing" of the division which has separated nurses in the profession. The nursing profession is more than ready for that kind of healing.

Progress within the nursing profession requires that nurses trust each other. Trust releases our creative energies to encounter the challenges of nursing together. With the establishment of trust, self esteem and self worth of each person are modified, magnified, and multiplied.

The authors of the papers within this book capture the best within us to potentiate our professional and personal self-esteem and self-worth by trust for each other.

Marilyn Rubin, RN, PhD
Chair, 1982-83

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The editors were ably assisted in preparation of the manuscript by Vicki Johnson, Administrative Secretary of MAIN.

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BIOGRAPHICAL SKETCHES

Leah L. Curtin, MS, F.A.A.N., Editor, Nursing Management, Cincinnati, Ohio. Noted for her work in nursing ethics. Ms. Curtin is founder and past director of the National Center for Nursing Ethics, and former editor of Update on Ethics and The Journal of Nursing Ethics. She also teaches at the College of Mt. Saint Joseph. In addition, she is the founding director of the Christian Family Health Center. Ms. Curtin graduated from the University of Cincinnati with BS and MS degrees, and the Anthenaeum of Ohio with an MA degree. She most recently co-authored Nursing Ethics: Theories and Pragmatics, a textbook used in colleges and universities in the U.S. and Canada. A helpful reading related to her presentation is, Nursing: Heads or Tails, Nursing Management, August, 1982.

Mary E. Fuller, RN, Vice President of Nursing, Sioux Valley Hospital, Sioux Falls, South Dakota, and adjunct professor, South Dakota State University, Brookings, South Dakota. In addition, she is Commissioner on the National Commission on Nursing. Prior to her position with Sioux Valley Hospital, Ms. Fuller worked for the University of Iowa Hospitals and Clinics in various capacities including, Associate Director, Director of Nursing, and Special Assistant to the Director of Nursing. A graduate of the University of Iowa College of Nursing, she is a member of Sigma Theta Tau, and the American Society for Nursing Service Administrators of which she was president. Ms. Fuller has written and spoken on many current issues in nursing management, including budget control and cost effectiveness, staffing, and quality assurance. A helpful reading related to her presentation is Nursing in Transition: Models for Successful Organizational Change, National Commission on Nursing, August, 1982.

Angela McBride, Ph.D, F.A.A.N., professor and chairperson, Graduate Department of Psychiatric/Mental Health Nursing, Indiana University School of Nursing, Indianapolis, Indiana. She is also an adjunct professor both in the Department of Psychology (Purdue University at Indianapolis) and the Department of Psychiatry (Indiana University). Dr. McBride, author of The Growth and Development of Mothers, and Living with Contradictions: A Married Feminist, has completed a new book, Larger Than Life: The Experience of Being Over Weight. She received her degrees from Georgetown, Yale and Purdue Universities. Childhood and Society, by Erik Erikson, is recommended reading in relation to Dr. McBride's presentation.

TRUST: AN IDEALISTIC OR REALISTIC GOAL?

by Leah L. Curtin, RN, MA, MS, FAAN
Editor, Nursing Management, Cincinnati, OH

"It is better to suffer wrong than to do it, and happier to be sometimes cheated than not to trust."

Samuel Johnson
The Rambler No. 79

Science, statistics, and studies are wonderful things. We have learned much from them. But sometimes we may become so engrossed in research findings and statistical computations that we lose sight of the obvious. For example, as I struggled -- and I do mean struggled -- to prepare this lecture, I plowed through numerous books written by psychologists, psychiatrists, sociologists, and other social scientists who examined, surveyed, compartmentalized, and dissected 'trust'. All of them shared at least one conclusion -- that we are suffering from a crisis of confidence today -- and none of them said anything that I particularly wanted to quote. So I had to turn to the obvious: my own experience and background.

What I wanted very much to do today was to speak to your hearts as well as to your heads, because I sincerely believe that effective nursing practice depends as much on the humanity of the nurse as it does on the nurse's knowledge and technical skills. Nurses who recognize and respond to the human needs of patients earn their trust and, in the process, discover a rich source of knowledge and understanding. Nurses who trust and support their colleagues, receive strength and support in return. I would like to elaborate on both of these points at some length.

In my career in nursing, I have learned more about trust -- its risks, rewards and responsibilities -- from patients and their families than from anyone else. As I sift through my memories, certain people appear in my mind's eye. For example, I remember John.

My first impression of John was that he seemed scarcely human and barely alive. Sixty-eight years old, 6

This speech was derived in part from Leah Curtin and M. Josephine Flaherty. Nursing Ethics: Theories and Pragmatics. R. J. Brady Company, Bowie, Maryland. 1982

foot 4 inches tall, and 94 pounds, he was semi-comatose and inert. Lying in his bed, his eyes staring unseeing at the ceiling, he responded to neither pain nor joy. John had been ill for months, and hospitalized for the last three weeks. His cancer of the bladder had eaten through his abdominal wall and his lower abdomen was one huge, raw, cancerous sore. His wife, his children, his brothers, a stranger -- all were the same to John. John's pastor, a Baptist minister, visited him and prayed for him, but John did not participate. The pastor asked him if he wanted to be baptized, but John said nothing.

Despite his unresponsiveness, I bathed his frail body gently, gave him his pain medication as often as possible, and changed his dressings frequently: I could only image the pain of urine in the raw wound. For weeks I cared for John and talked to him, his condition never changed.

One morning I entered John's room to bathe him. I began, as usual, by washing his face - and John looked at me. I mean really looked straight in my eyes. He didn't say anything, he didn't even try to speak, but two big tears formed and slid down his cheeks. His brother was outside the room. I brought him in. He tried to talk to John - and then he turned to me and said "I have to leave, I can't stand it." I sent for John's doctor, his wife, and his pastor.

His eyes wouldn't let me go. When I bent over John's bed and took his hand, again tears were in his eyes. John had to trust me to interpret his wishes. What did he want? I went to the washroom, got a glass with a little water in it and baptized John. As I said the final words, John put his arm around my shoulders and pulled my head down to his chest. Then, peacefully, silently, with strength, John died. A man who had never spoken to me, a man of different faith and race, a man whose whole existence seemed to be made up of pain and loneliness: this man gave me a gift I still treasure and use -- a gift of thanks, of faith, of strength, and an abiding belief in the value of each human being.

And then there was little Christy. Christy was a three year old girl who was dying of lymphosarcoma. One day I was entering Christy's room to administer some medications, I heard her say to her mother, "Mommy, what's it like to die?" I stopped, frozen in mid-step, as her mother responded, "Honey, do you remember when you were at home and you would fall asleep downstairs? Daddy would pick you up in his arms and carry you upstairs and everything would be all right. Well, dying is something like that, only this time God will pick you up in his arms and then everything will be all right." I entered the room, gave Christy

her medications, said a few words to her mother and then left.

Several days later on the night shift, I entered Christy's room to find Christy sleeping, but her mother was sitting in the chair crying. I stopped to sit with her for a few minutes. When Christy's dad arrived to take over the night vigil, I suggested that both parents go down to the automat for a cup of coffee and a few minutes alone together. I promised that I would not leave Christy alone. Christy's parents trusted me with their dying child.

Less than 10 minutes after her parents left, Christy awoke. She was struggling to breathe and she was very frightened. The pediatric resident and the chaplain were called and an aide was dispatched to the automat to get Christy's parents.

I lifted her small head and shoulders in a futile effort to ease her breathing. I felt enormously inadequate until I remembered what her mother had told her. I picked Christy up in my arms, rested her head against my shoulder and held her close to me. Christy stopped crying and struggling. The fear left her eyes. Her breathing became more regular and she relaxed. Christy died like that, in my arms.

I stood there holding Christy for what seemed like a very long time, but it couldn't have been more than a few minutes. Her parents arrived first and we gently tucked Christy into bed. She looked quite beautiful. Softly, I told her parents what had happended -- that Christy had not been alone or frightened. I gave her parents what little comfort I could and in return, they gave me a share of their gentleness and courage. Within moments, the resident and chaplain arrived. This entire episode occurred in less than half and hour almost twenty years ago, but you do not forget.

No, you do not forget. Then, there was Mary -- a sixty two year old diabetic who had lost one leg to gangrene. As a visiting nurse, I was to teach her about her diabetes, how to test her urine and how to give herself insulin. But that wasn't enough for Mary. She looked me right in the eye and said, "Nurse, I want to walk up the stairs of my church on my own two feet and stand there, praising God. Will you help me?"

It was a long struggle against what seemed at times overwhelming odds - Mary's other leg was in poor condition. She had no regular physician, there was no money to pay for an artificial limb, and there was pain, discouragement, and exahaustion to combat time and again - and we had to do all this in the home. Mary never doubted me for a moment. She

believed in God, in herself and in my ability. She trusted me. A year and a half later, Mary climbed the steps of her church on her husband's arm and stood there while the entire congregation sang "Praise God." I helped Mary walk, but Mary gave me the gift of self-confidence.

Then there was 82 year old Mr. Brown who was afraid of my safety during the riots in Cincinnati. He would wait by his window for me every day and - rain or shine - escort me to and from my car. I gave him medicine, but he gave to me a gift of fidelity. And Mr. Wright, and Vincent Paul, and Maggie Smith - who placed her trust in me merely because I held her hand while the physicians did a sternal tap on her.

What I have had to say is not scientific - perhaps not even cerebral. It requires what philosophers call a leap of faith - the risk of departing from the safety of facts to the insecurity of risk - and the ability to risk one's self is probably the essence of trust. So often we look at patients, at their needs, and problems, and we focus on what we will do for them. What we will give them - and we often forget what they give us. Yet, without the trust patients place in us, we could not practice.

We are members of a service profession. We have made certain commitments and we are bound by them. Commitment in the profession of nursing raises at least two questions: What does being a professional involve? And even more puzzling, what does it mean to be a professional nurse?

The question of how the nurse is committed to the patient or client necessarily involves what it means to be a professional. The word profession has its root in the Latin word "profitere" that literally means "to declare publicly", i.e., to promise publicly.

The philosopher J. L. Austin developed the now famous distinction between two different kinds of statements: descriptive and performative. Descriptive statements transmit, describe, or reveal a reality in the world. For example, "The tree outside my window is forty feet high," or "You have cancer of the lung." Or, "Your child was born with a condition called meningomyelocele." Such statements don't change reality, they merely transmit it.

Performative statements, however, actually alter reality by introducing a new ingredient - something that would not be there apart from the declaration. For example, "I, Mary, take thee, John, to be my wedded spouse, or "I will help you. I will not let you lie in feces and urine. I will not abandon you." Such statements actually change reality; they alter the living experience of the people who make them and the people to whom they are made.

Precisely because a promise is a link between what is and what will be, to make or to break a promise is a very serious thing to do. By and large, the question of honesty among health professionals has been limited to discussions of whether to tell patients the descriptive truth. But the real questions about honesty among health professionals entail whether or not the patient experiences the performative truth. The performative declarations of a professional expand the demands of honesty in the professional's life.

So, the moral question for the health professional is not merely a matter of telling the descriptive truth, but rather, of being true to the promises of the profession. That is, honesty among health professionals not only entails truthfulness, but also fidelity.

For professionals to practice effectively, they must have the public's trust. There is no such thing as an inherent right to be trusted; it is a privilege that one earns. To trust a professional, a patient or client must believe (1) that this individual has the knowledge necessary to help him, and (2) that this person will act in his best interests.

The first involves possession of a knowledge base and skill, but the second involves commitment: What promises do both the profession and the professional make? Nursing's promises are (1) to help the ill regain health; (2) to help the healthy maintain health; (3) to help those who cannot be cured to maximize their potentials; and (4) to help those who are dying to live as fully as possible until they die.

Because the degree of trust granted by the public to a profession rests squarely on the shoulders of individual practitioners, the consequences of the presence or absence of fidelity in individual nurses are enormous. The total situation for patients includes not only the disease or disability they have, but also whether someone will care for them or abandon them through the course of their disease or through their dying. Taken as a whole, the performative declaration of the nursing profession commits each nurse to address that difference, i.e., the difference in how patients live out their lives.

Although it is true that the fidelity of the nurse cannot change certain facts (the fact that a person is irreversibly dying; the fact that a child is born with a severely handicapping condition; the fact that a person is quadriplegic as a result of a trauma or disease), the conditions in which people live out these facts can be changed. It is nursing's responsibility to create an atmosphere in which people can actualize their potentials and live

their lives as fully as possible. Nursing assessments revolve around identification of an individuals's quality of life to enable nurses to improve the patient's quality of life. This is the moral imperative of nursing practice. Indeed, it describes how the nurse is committed to the patient. To the degree that nurses are faithful to this commitment, they will alter the reality of the lives of patients or clients and their families.

Unforunately, professions develop unevenly because the professionals who comprise them are in diverse states of awareness, intellectual attainment, and commitment. The practitioner's perceptions of their roles and character traits will affect the problems they see, the personal presence they bring to them, the manner in which they address them, and the reservoir of personal resources they can call upon to serve another day. At the same time, their moral commitments (or lack of them), as repeated in thousands of their colleagues, will create or destroy the profession.

Practicing a profession involves internalizing a philosophy, perceiving what is congruent with it and developing a discretion that enables one to recognize what is "fitting" or appropriate within this role. Among other things, it raises the questions of professional standards, self-regulation, and self-discipline.

The problem of maintaining professional standards goes to the heart of a profession's obligations to society. We tend to avoid this problem because it involves questions of the style, virtue, and character of individual practitioners. It is difficult and chastening to any professional because we all are aware of our own shortcomings.

Nonetheless, the license to practice does not include permission to practice poorly: It presupposes an obligation to practice well. Before a license to practice can be granted, society must grant the power to license to the professions through state laws. If the license to practice entails an obligation to practice well, the power to license requires as a necessary consequence the obligation to judge and to monitor well the practice of individual practitioners. As individual members of a profession, we share this obligation of assuring that established standards of practice are followed by all members of the profession. Precisely how we go about doing this forms the basis of our intraprofessional relationships.

To achieve nursing's goals - to fulfill its commitments - nurses must begin to pay serious attention to the relationships that actually do pertain among nurses, and to the kind of relationships that ought to pertain among nurses themselves and between each nurse and his or her profession. Are they trust relationships? Is trust pos-

sible or desirable? Is it only for the naive among us? Are our colleagues worthy of trust? Are we trustworthy?

The ethics of a profession not only delimit the role and scope of its activities and prescribe the nature of the relationship that should pertain between its members and the lay public, but aslo establish the duties professionals owe to one another and to the profession. The ancients recognized the unique nature of the professional relationship and formalized it in the Hippocratic Oath: "I swear...to hold him who has taught me this as equal to my parents and to live my life in partnership with him."

In addition, codes of ethics usually included a pledge to exert one's best efforts to maintain the honor of the profession, to uphold its public standing, and to expand the bounds of its usefulness.

Nurses, then, as they assume their professional identities, are pledged to: (1) the work of understanding, interpreting, and expanding the body of the profession's knowledge; (2) the equally disciplined work of criticism and self-regulation; and (3) the work of developing and cultivating in themselves and their colleagues the character traits upon which professional excellence depend, and, certainly, trustworthiness is foremost among these.

The moral commitments of nurses to their profession and to one another form a foundation for professional life. The practitioners' perception of fidelity to these moral commitments will affect and, to a large extent, create the structure of their intraprofessional relationships. That is, insofar as nurses recognize their commitment to the same goals, their common knowledge base and the debt they owe to their teachers, predecessors, and peers; they will devote themselves to the advancement of the profession and to the growth of their colleagues.

The importance of intraprofessional relationships often is appreciated insufficiently because nurses, and rightly so, focus their concern on the well-being of patients or clients and their families. However, mature recognition of their own limits and capabilities requires nurses to rely upon and incorporate the research, experience, and knowledge of other professionals in their own practice. Clearly, even the structure of work in most facilities requires nurses to function interdependently, i.e., to trust in the professional expertise of their colleagues as each strives to achieve personal and professional goals. In a very real way, nurses' interdependence demands a special, even fraternal, relationship between them.

The ethical principles that underly the formulation of professional relationships derive from several sources. The first source is comprised of the universally applicable concept of human rights and the duties attached to those rights. Nurses are human beings first and they deserve to be treated as such by all persons -- including other nurses. As with all relationships, nurses' mutual humanity forms the fundamental framework for relationships among the people who happen to belong to the same profession. Therefore, the relationships that obtain between nurses should be characterized first and foremost by respect for one another's human rights.

A second source of the ethical principles that underlie professional relationships derives from nurses' shared obligations to promote the public's welfare. Because nurses are professionals, they are responsible to the public for the services rendered by the profession as a whole. As professionals, nurses assume a duty to practice in accord with established standards and to improve standards as knowledge increases.

One of the most effective ways to promote excellence in nursing practice and to disseminate new information is to offer support, guidance, criticism, and direction to one another. To fail or to refuse to offer this kind of assistance to one another actually constitutes a breach of faith, not just with colleagues, but also with the public because it will negatively affect the services offered to them.

While human rights and concern for the public's welfare form a basic framework for the special nature of intraprofessional relationships, the third source of the underlying ethical principles breathes life into them. When nurses enter the profession, they figuratively "adopt" their coleagues as brothers or sisters. The special ethical obligations flowing from this source derive from the professional <u>bond</u>, rather than from blood ties or mutual liking.

Typically, the duties ascribed to the 'fraternal' aspects of professional relationships are formalized into rules regarding the handling of incompetent colleagues, canons of loyalty, and professional courtesies. However, these superficial manifestations of the professional bond only begin to approach the realities of the human experience that is the professional relationship.

Professional relationships <u>enable</u> one to be a professional (specifically, a nursing professional) through identification with others and through finding again the dilemmas of others within oneself. That is, such relationships do not tell one how to act so much as <u>how to be</u>. The

discovery and understanding of oneself as a professional inexorably results from one's perception and knowledge of other professionals. More importantly, each discovers the outline of herself in the human totality of her colleagues; each recognizes herself in others and the character of others in herself. More precisely and powerfully, between their first experience of the professional relationships and their last, professionals actually exchange characters. The interchange of characters between self and others creates what one is as a nurse and, at the same time, the ideal of what a nurse should be in general and in particular.

In terms of the sociology of the profession, the function of the professional bond may be described as role-modeling and role internalization. Ironically, the deficits in role inculcation probably relate to the educational model adopted by the nursing dicipline. In misguided attempts to improve the educational status of nursing, students often have been 'protected' from interaction with practicing nurses, with the rationalization that such interaction smacks of apprenticeship. As a result, the professional bond in nursing is weak and professional identity often fails to develop. The failures are evident in the large number of nurses who leave the field and those who practice at sub-professional levels (regardless of what degree or credentials they earn).

Only as nurses discover and create their own practices will they discover, add to, and create their profession. In the end, the sources of ethical principles underlying professional relationships - human rights, commitment to the public welfare, and the professional bond - give structure and life to the practitioners' experience of the profession which, in turn, revitalizes the profession itself. Where positive professional relationships are weak or absent, both the profession and the professional suffer.

Unfortunately, contemporary nurses have been far less interested than their predecessors in the identification and cultivation of those character traits necessary to the life of a profession. This may be due in part to the almost monastic life previously demanded of nurses and in part due to the fact that reflection in this area may seem too subjective and elusive. Whatever the reason, the result is that too little thought has been given to the question of those virtues appropriate to the development of professional character.

To enter fully into a professional relationship with one's peers, that is, to deserve <u>trust</u> from one's colleagues, requires:

1) fidelity to the promises of the profession: A shared commitment to the profession's goals provides identity to the group and forms a solid foundation for cooperative effort.

2) respect for the human and earned rights of oneself and one's colleagues and exquisite respect for the rights of patients or clients. Self respect enables one to stand up for one's beliefs. Respect for others infers an openness to discussion and debate to clarify differences of opinion, fact and intent. Both are essential to healthy relationships.

3) honesty and intellectual integrity. At the very heart of 'a community of scholars', these virtues are essential to trust relationships within the profession and between the profession and the public.

If these character traits are appropriate to professional life, then the virtues nurses must look for and nurture in themselves and others are benevolence, honesty, respect, fidelity, and integrity. Without these virtues, the moral fiber of the profession is weakened and the activities of the profession itself will be reduced to commercial transactions at best. The dictum, caveat emptor (let the buyer beware) certainly is not an appropriate motto for nursing. If matters of professional virtue - and the presence or absence of it in each nurse - are not addressed, the vast resources of the profession will end up being for sale to the highest bidder.

If nursing is to become and to remain a justifiable and viable profession, three developments must take place. All are possible because all exist, although in muted form, today.

First, the profession must recover and nurture a sense of commitment among its members. The knowledge nurses amass and the skills they acquire are more a public trust than a private acquisition to be prized and sold on the open market. Nurses' current preoccupation with their economic status is salutary in its own way, but extraordinarily vulnerable because it is far too narcissistic a focus for a profession. Opportunities for financial gain and personal advancement in a profession flourish only in the context of the valuable service the profession provides to the public. The utility and advance of the profession depend upon individual members who have some sense of professional identity, commitment, and responsibility.

When the professional bond is weak and each practitioner thinks of himself or herself as an entrepreneur - alone, uninvested with a public and professional trust - the profession is wounded, perhaps mortally. By virtue of its traditions and its contract with society, nursing can ill afford to deny its public function, the interdependence of its members, or its inherently altruistic goals. However, to engage in critical inquiry into the tension between altruistic service and adequate remuneration is, itself, a social act that infers accountability and responsibility for judgements and decisions and assumes that these actions can be evaluated by the public. Critical inquiry is part of the public life of the mind, an indispensible ingredient to a professional life that has more to offer than technical service for personal gain. Such inquiry necessarily includes a weighing and weighting of the values, obligations, and goals of the practitioner and of the profession.

Second, members of the nursing profession must become far more aware of their responsibilities to one another. Nurses must recognize more fully than they have before their duty to support, nurture, guide, and correct one another. Cooperation and mutual growth must be recognized widely as the norm in professional relationships - not competition, one-upmanship or acquisition of power. Practically speaking, one's own success depends largely upon the knowledge and skill of one's colleagues as well as upon their willingness to share information and insight and to engage in constructive criticism. The nurse-nurse relationship is the one, vital, living factor that is inexplicably weak and without which nurses will be unable to fulfill their commitments to the public and to achieve personal and professional goals.

Third, nursing must address the systems, institutions, and structures that shape in advance the environment in which nurses practice. Indeed, the ethical spirit of the profession today has been shaped largely by institutions - both of learning and of work. Therefore, it is appropriate and necessary for nurses to examine these institutions and to seek to improve them.

Do schools of nursing prepare students to engage in critical inquiry into the values that shape society and the profession? Are they developing the kind of professional who can function effectively to meet the needs of the public and to advance the profession? Do nurses' work places provide an environment conducive to excellence in nursing practice? Does the socialization process both in schools and workplaces promote the development of a professional bond and of trust among nurses? But, then, that's why we've come together in this conference: to explore the answers to these questions.

So, to conclude my remarks today, I will paraphrase the words of the noted British art historian, Sir Kenneth Clarke, and, perhaps, put some of my personal values up front just in case I haven't been clear about them. You see, I prefer negotiation to confrontation. I prefer gentleness to aggression, trust to cynicism.

On the whole, I think that knowledge is preferable to ignorance, and I am sure that human compassion is more valuable than anyone's ideology. I believe that, in spite of the recent and future triumphs of science and technology, human beings themselves haven't changed much in the last five thousand years, and we still have much to learn about and from them; and scientific and sociological studies take us only half way. They reach men's minds, but not their hearts.

I also hold one or two beliefs that are more difficult to put in concise terms. For example, I believe in courtesy; the ritual by which we avoid hurting other people's feelings in order to satisfy our own egos. And I think we should remember that we are part of a truly humanitarian endeavor which, for convenience, we call health care. None of us can achieve personal or professional goals unless we learn to trust one another. All the people - patients, families, co-workers, educators and administrators - are our colleagues in this mission. We deserve their respect and trust only to the extent that we give them ours. Trust is not so much a goal in life as it is a <u>necessity</u> of life.

Above all, I believe - I trust in the God-given genius of certain individuals, many of whom are my colleagues in nursing, and I value the institutions, the profession, and the society that makes their existence possible.

DYNAMICS OF TRUST IN PROFESSIONAL RELATIONSHIPS

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This discussion will begin with some commentary on the importance of trust in professional relationships. Some data will then be presented regarding what promotes or limits the development of nurses' trust in each other. Finally, three particular strategies for the development of trust will be discussed: (1) the influence of competency issues on trust; (2) the importance of common goals to trust; and (3) the relationship of governance issues to trust.

THE IMPORTANCE OF TRUST

Erik Erikson is probably the one person most identified with considerations of trust. In his much-quoted stages of psychosocial development (Erikson, 1963), issues of "trust vs. mistrust" characterize the first stage of individual development. The young child learns to count on caregivers and begins to risk crawling towards something or someone new, safe in the knowledge that the trusted parent will be there to "kiss away the hurt" should that be the price for independence and curiosity.

Streff (1981), a psychiatric clinical nurse specialist, integrated Erikson's model of individual development with that used by Duvall (1977) in her examination of the stages of the family life cycle, for the purpose of explicating her own model of family growth and development. The first stage of this model focuses on the couple coming to trust each other: "The sharing of thoughts and feelings about one another; the hopes, dreams, goals, and expectations are slowly begun in an atmosphere of nascent trust" (p. 64). Trust is considered to be the foundation for self-revelation and risk-taking in the development of family life.

Also, trust is the first stage in the development of one's professional relationships. You need to establish mutual goals, open and honest communication, and an appropriate dependence-independence-interdependence pattern with colleagues before any joint venture can be brought to fruition. If you do not trust your colleagues, you will have difficulty relating to them and working with them.

Trust is a basic feature of all interpersonal situations that demand collaboration (Johnson-George & Swap, 1982). It is most generally defined "as a belief by a per-

1982). It is most generally defined "as a belief by a person in the integrity of another person" (Larzelere & Huston, 1980, p. 595).

Deutsch (1962) described trust as consisting of actions that increase one's vulnerability to another (whose behavior is not under one's control) in a situation where the penalty one suffers if the other abuses that vulnerability is greater than the benefit gained if the other does not abuse that vulnerability. If you trust, you risk self-disclosure and accept more influence from others, in the hope of achieving more in collaboration than you can accomplish alone.

Carl Rogers (1961) saw many benefits to trust; he considered trust to be causally related to intellectual development, originality, emotional stability, and self-control. Hollander (1978, p. 9) described trust as essential to the leader-follower relationship:

> With trust, the leader and followers are more willing to take risks and to tolerate the costs involved in the relationship. Without trust, the leader must resort to assertions of authority. Similarly, followers may feel that they must make demands for their rights in confrontations with the leader. The presence of trust, which grows out of experience and takes time to develop, is a powerful force in reducing the need for these tactics.

Trust, in this view, is intimately connected with colleagues developing a sense of fair play regarding each other. No one has to worry about being exploited.

WHAT PROMOTES OR LIMITS NURSES TRUSTING EACH OTHER?

Given that trust is fundamental to the development of productive professional relationships, what promotes or limits nurses trusting each other? In order to have a sense of how some nurses conceptualize the dynamics of trust, I canvassed the faculty at Indiana University School of Nursing, Indianapolis, for their thoughts on this matter. I wanted this paper to go beyond either my impressions on this subject or the relatively little that has been written on the dynamics of trust in nursing journals.

Thirty-nine out of 150 faculty members responded to my query, which took the form of a memo asking four general questions. One faculty member thought the questions were so relevant to the graduate-level course on Nursing Issues that she asked students to respond to these same questions; fifteen students did so. Therefore, the impressions that will be presented are based on the responses of 54 post-baccalaureate nurses.

Bear in mind that the respondents do not constitute anything approaching a random sample. They work and study in a specific geographic context, so the generalizability of their viewpoints is dubious. Indeed, there is reason to believe that those who responded to my query may be the very ones most bothered by issues of trust. One faculty member, poignantly wrote at the end of her comments, "I plan to leave nursing for one reason -- just because of this issue"; that is, the features of academic nursing that limit our ability to trust one another.

Even though the responses to my query should be treated as impressions, and not as data with demonstrated validity and reliability, it is noteworthy that the points made by this sample reflect some of the key issues about trust found in the literature.

For example, the need to have shared goals is fundamental to the development of cooperation (Ray & Flynn, 1980). When immediate self-interest is not subordinated to long range gain, the relationship tends to deteriorate into a self-defeating competition (Solomon, 1960). Those who are trusting and trustworthy expect the same behavior from others; those who are suspicious and untrustworthy expect the same behavior from others (Deutsch, 1960).

To the question, "What do you think facilitates nurses trusting each other?" the following answers were offered by five or more respondents (in descending order of importance):

1. Open and honest communication is established between colleagues; criticism is always constructive.

2. You respect the knowledge and competencies of your colleagues, and they respect your capabilities.

3. Common professional goals are held by nurses.

4. A support system is built into your professional world (especially support for difficult situations).

5. Your professional accomplishments are acknowledged and applauded by other nurses.

6. You are personally willing to take risks and be vulnerable.

7. Colleagues are circumspect about confidences.

8. Leadership is consistent and even-handed (especially about rewards).

9. All in your system have some say in decision-making.

10. Each nurse has a sense of self-esteem and self-acceptance.

11. You have a personal experience history of others "coming through" for you.

12. Trust begets trust (i.e., people are what we expect them to be).

To the question, "What do you think gets in the way of nurses trusting each other?" -- the following answers were offered by five or more respondents (in descending order of importance):

1. Nurses feel inadequate, insecure, and lack self-acceptance.

2. There is too much emphasis on individual achievement, independent work, and competition (especially for limited resources).

3. Colleagues do not acknowledge and applaud each other's professional accomplishments.

4. There is so much diversity in nursing; there are different competency levels which, in turn, limit the number of goals which nurses share in common with each other. Moreover, we do not understand each other's job.

5. Nurses may lack communication skills; they may have inadequate conflict resolution skills and may know only how to talk about people (with the result that their words sound like personal attacks) and not about problems.

6. The standards of practice are inconsistent and ill-defined, but responsibilities are constantly being increased.

7. Nurses are overworked; each is pressured to be a teacher-researcher-writer-practitioner-administrator.

8. Nursing systems are inflexible; when the rule is "What is is what ought to be," any deviations from standard practice are suspect, and risk-taking is squelched.

9. Nursing leadership is frequently autocratic and inconsistent, therefore, information may not be shared regularly and all may not feel as if they are parties to decision-making.

10. There is little or no time in the work setting for coleagial discussions.

11. Nurses may not have a personal experience history of others "coming through" for them.

12. Nursing systems are typically large and impersonal; nurses may, therefore, not feel connected with each other.

13. As a profession peopled largely by women, both our second-class status and our jealousies get in the way of nurses trusting each other.

14. Some nurses are not competent, and they do not inspire trust.

15. Some nurses are not circumspect when confidences are exchanged.

When you compare the list of what promotes trust with that of what limits trust, you find that -- to a considerable extent -- one is the inverse of the other. Communication skills can enhance the development of trust or a lack thereof can limit it. Common goals help; diversity is problematic.

Previous experience with trust relationships facilitates trusting again; not having such a personal history works against the development of trust. When your professional accomplishments are applauded by your colleagues, you feel positively disposed to other nurses; when they are not, you feel alienated. The nurse with self-esteem and self-acceptance is predisposed to trust other nurses; the nurse without a positive sense of self my feel too vulnerable to risk self-disclosure.

There are differences between the two lists. A few more explanations were given for what limits the development of trust than for what promotes it. This is in keeping with the fact that the majority of the respondents indicated in some way that trust in professional relationships was a problem in their lives.

It is interesting to note that the two lists also vary in terms of whether the emphasis is on explanations internal to individual nurses (e.g., communication skills, respect for competencies, willingness to take risks, being circumspect, and personal history) or on structual factors

(e.g., inflexible systems, ill-defined standards, autocratic leadership, impersonal systems, and women's status in society).

Two-thirds of the factors responsible for the promotion of trust concerned qualities of individual nurses. On the other hand, structural factors were invoked more often (60%) to explain why nurses do not trust each other.

When these same respondents were asked to identify those features of nurses' educational preparation and/or socialization that facilitate or suppress nurses trusting each other, many of the items mentioned in the two previous lists were cited once again. The educational sustem was described as fast paced, highly competitive, fostering conformist behavior, making students feel inadequate, and focusing too much on students' acting independently.

A couple of respondents pointed to the fact that females have little or no childhood experience with team sports which leaves them ill-prepared for the rough-and-tumble of group play. Girls may whisper secrets to each other in playground cliques that are defined more by who is out than who is in, but they may have little or no personal history of furiously arguing over an interpretation of a game rule then seeing differences dissolve in the rosy glow of a team victory. These socialization differences may predispose women to eschew any situation that gives the appearance of conflict, because they have no first hand experiences with working out differences of opinion -- you are either a best friend or you are not to be trusted.

The respondents strongly believed that the best way our educational system can encourage nurses to trust each other is by the faculty acting as role models. If they obviously respect their colleagues and enter into collaboration with them (especially with those who are in service), then students will learn to trust each other. This can be further enhanced by having some class projects involve small group collaboration. The emphasis in evaluations should be on where the person is in her/his growth, and not on how inadequate the person is professionally.

STRATEGIES FOR THE DEVELOPMENT OF TRUST

Many of the comments made by the 54 post-baccalaureate respondents offered useful strategies for the development of trust. Three are particularly appealing, based on personal experience.

Competency Issues

It is my observation that a large percentage of nurses either do not feel competent or do not regard other nurses as competent. This came out in the canvassing of colleagues. Lack of trust is attributed first and foremost to nurses feeling inadequate, insecure, and low on self-acceptance. Moreover, colleagues are perceived as neither acknowledging nor applauding one's professional accomplishments. I think that this state of affairs is related to both the notion that nurses are expected to be all things to all people (i.e., a teacher-researcher-writer-practitioner-administrator-theorist-change agent, preferably all at the same time), and to the fact that there is often no real appreciation of each other's job. One cannot feel secure and adequate if performance expectations of one's job always seem to be escalating. You are not likely to recognize someone else's achievements if you either do not know anything about her/him or do not fully comprehend how complicated her/his job really is.

Read some definitions of nursing, and you get the impression that your personal mandate is to do <u>everything</u> for people in need of <u>anything</u>. How can you feel truly competent when there is no apparent end to what you could or should do for people? Against such a mountain of expectations, your accomplishments can hardly be noticed. Nurses often do not properly distinguish between what they take to be their own personal responsibilities and the overall mandate of the profession itself. Further, common-sense language is so frequently used to describe nursing (e.g., nurse as mother surrogate, or socializing agent) that you may be left with the impression that competency is not the basis for practice, but rather being maternal or social. We forget that sense is not necessarily common, and that it may take years of experience to be able to give others the impression that your practice flows "naturally" from your person.

These reflections lead me to make several suggestions:

1. The competencies of nurses in different settings need to be publicized in hospital or school newsletters (so often newsletters have focused on marriage and birth announcements and not on professional accomplishments), local media, etc. There is no one image of nursing; there are many images. It is not one career, but a profession with the possibility for many different careers over a professional lifetime. We need to publicize the sense of richness and diversity.

2. What nurses actually do needs to be described on end-of-the-year evaluations and other documents describing present practice. Too often the focus of such forms is on what nurses are not doing. (How many research grants have you gotten during the last year? How many of your articles have been accepted through a process of blind review?), and not on what they are doing. Indeed, titles should be created such as "Coordinator of Clinical Placements," or "Recruitment Officer for the Department" if some task that takes a particularly large portion of time is invisible in the present system.

3. Remember every time you write a colleague a note of congratulations, you are doubly enhanced. You have acknowledged another nurse's competency, and you are simultaneously acknowledging your own professional stature. People who bother to write letters of congratulation are re-affirming both that they are discerning and that their opinions matter.

4. We as a profession need to develop our tolerance for ambiguity and imperfection. We often feel that we have to be twice as good to be any good. You may never write an article if you wait for it to be 100% perfect; two 85% perfect articles published in the time that it takes to write one which is 100% perfect gives you 170 points (rather than 100 points) by my accounting. If you always expect either perfection or complete resolutions, you may never feel either competent or satisfied with yourself.

My suggestions all have in common an appreciation for each other's competencies.

Common Goals

Communication skills were described as the primary explanation for the development of trust in my survey. When we think of communication skills, so often the emphasis is on the raw expression of feelings. When we think of support groups, we often equate support with vindication of our feelings. Sometimes we naively focus on feelings in a way that leads to unhealthy ruminating instead of necessarily leading to healthy catharsis. You go over and over some of your negative feelings and instead of being cleansed of them you find yourself more entrenched in an "us-vs-them" view of professional life.

Nursing educators have long urged the development of communication skills in practitioners, but I am not sure that they are convinced of their worth. Moreover, we have all too frequently not included conflict resolution strategies and reframing techniques as part of the subject matter.

With the many competency levels and specialty areas in professional nursing, we need to focus more on how two seemingly different viewpoints can be reconceptualized as two different examples of the same professional objective. For example, both service and education are concerned with quality practice. Instead of constantly emphasizing the tensions between practice and service, why not jointly explore how students can be helped to function well in their post-graduate lives when they may never again have the time to carry out each and every step mentioned in the process of learning how to conceptualize ideal nursing care?

Instead of treating tensions between individuals and organizations as if confrontation is the cure-all, and as if one side will eventually be found to be in the right, we need to hone our mediation skills. Mediators work toward a common ground. This would mean declaring a ban on turfism, ad hominem attacks, and gossip-mongering. Certainly, those who responded to my survey seemed ready for such an approach.

Governance Issues

For professional competencies to be appreciated and common goals to be promulgated, governance issues need to be addressed. If the nurse was once conceptualized as the "good mother," then the administrator was too often regarded as "big mama" who kept her children in line with guilt, a stranglehold on the pocketbook, and pieties. For professional trust to develop, however, leaders need to be facilitators of their staff's competencies. Information cannot be hoarded in paternalistic or maternalistic fashion: "I know what is good for you, and I will let you know all that you need to know." Rewards have to be handed out equitably. If responsibilities are handed out, then so should authority and resources.

Governance issues are especially important as evidenced by my respondents' many explanations of lack of trust in terms of structural matters. Too often administrators -- feeling inadequate, insecure, and incompetent themselves -- shrug off their staff's complaints of lack of time, being overworked, and underpaid as if these complaints were either unfounded in reality or immutable facts of life. The staff, for their part, frequently turn a deaf ear to the perspective the administrator may have of an entire organizational system. This leads to a split be-

tween staff and administration that rivals the one between service and education for lack of mutual trust. The way out of this impasse is for each side to recognize and support each other's competencies, and to focus on common goals.

The various strategies for developing trust in professional relationships are interconnected. The person who is open, competent, consistent, and circumspect invites trust. When two or more such nurses get together for a common purpose, they and their profession cannot help but be enhanced.

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Question:

I have a couple of concerns, Angela. When I hear the presentations on trust as a global concept in relation to nursing in general I have some concerns. How does one handle situations where for some things you can trust and for other things you can't? And, I heard a comment earlier that it is difficult to work with people you don't trust. Well, if that were true across all behaviors I would agree, but isn't it possible that there are some aspects of the person or the role that you can rely on and others that you can't. How do you manage that in your scheme of things?

Answer:

I see your comments as a welcome correction to talking globally because, in fact, when the question is: What do we do in my own system? that becomes very specific. Your point, was that trust is not 100% or 0%. What happens is you focus, in your relationships with people, on those areas that you <u>can</u> trust. And you try to enlarge those areas by doing some of the things that I suggested, such as looking at common goals so that you can see the areas that you might enlarge. Even as you talk about that area, there may be an enlarging of it so that you can each build more trust into the relationship. If I go into a system as a nurse educator, some may say: "She knows nothing about <u>real</u> nursing." Or I may go into a service situation conveying the impression that I am not convinced that staff on the unit are 'with it'. I may believe staff are nice and efficient in their behaviors, but I may be thinking: Have these staff nurses expressed their theoretical basis for practice and tested it lately? Those are two diametrically opposite spots in terms of service and education which may be brought closer together; first, by seeing where you can trust one another, and then by trying to enlarge on that. Thus, in a particular situation you try to look for common goals, or increase your real knowledge of each others' competencies in areas of practice or education where you can both be open.

We tend to test our relationships with people, to see how open and honest we can be with them. Openness can lead to a common way of working out differences that becomes easier, more efficient, and more trusting each sucessive time we work together. Over time, the goal is to continue to enlarge and secure these areas of trust relationships.

REWARDS AND RISKS OF TRUST RELATIONSHIPS

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By the conclusion of this conference, trust should have a more meaningful operational definition internalized by all of us, and we should have acquired some new interpersonal skills with which to work. Today I will talk interrelate aspects of trust with the National Commission on Nursing, and comment about shared goverance of organized departments of nursing. I will also talk about mentoring and summarize by giving you a little background to support my conclusions. The conclusions are intended to be a mandate to our professional organizations. That accomplished, I plan to get out of town in a hurry because some of what I have to say will be controversial.

First of all, trust is a very dynamic concept. It is never a static concept. If what I said twenty years ago and what I say today are different you might say I am untrustworthy because my position today is not the same position I took twenty years ago. Trustworthiness is a stable characteristic but it is not static. We trust each other to do the very best job that we can do at any particular moment, with the information that we have at that moment. And then we forgive one another or we trust that because times have changed we must change those positions or attitudes. We may redefine the issues, as we watch the pendulum of values swing.

The experience of working in an environment in which trust must be earned is very common among nurses. The successful head nurse is the one who "has earned the trust of the staff". The nursing admistrator is successful when she is considered trustworthy by the staff. The nursing educator has her own measures of trust with her colleages. The 'information' era that we are entering is aptly described in "Megatrends". Naisbitt, (1982), describes a rather distrustful total world environment that leaves us wondering upon what information we may depend.

New staff nurses face a work environment with this same kind of insecurity. Their co-workers are often older more experience; and they may be prepared in a different educational system than the newcomer. The nursing student is a recipient of the attitudes and the beliefs of his/her teachers, who in turn are products of their own experiences, and of the current national priorities in health

care. The effort to contain or reduce costs gives the nurse of today a different environment than any we have nursed in before. Suddenly productivity seems to be more important than quality. The new nurse is experiencing a changing administrative attitude about the difference between what a patient needs and what nursing wants the patient to receive from the nursing care giver. These are two different aspects of a developing dilemma.

Not to belabor this point, I would nevertheless call your attention to the evolving social and ethical issues that are being redefined at the nursing unit level --- who shall die, how shall they die, and where shall they die. Whether or not these matters create a more distrustful environment or not I leave to you. We have adapted our nursing to accommodate many changes in technology in the past, but the challenge is more profound now than ever before.

In "Megatrends" a reference is made to "time folding." This is an especially descriptive term related to the special problems of nursing and health care right now. Our instant, global communications systems are such that a California problem, can also become a South Dakota problem the instant it is presented through the media. We have lost our ability to have a little time and a little space between problems. We are involved in everything around us more intimately and immediately than we might sometimes wish. This is what is meant by "time folding".

We can all reflect back on experiences similar to those described by Leah Curtin. The patients may have different names and be in different settings, but those experiences are the very occurrences that committed us to the nursing profession over and over again. With "time folding" the human trusting, professionally satisfying interchanges with patients become a "fast-forward" blur, with little time to reflect, or appreciate the value of the events of our daily professional lives.

National Commission on Nursing

In 1979 the National Commission on Nursing (NCN) was formed, supported by private funding. Thirty-one health care professionals have served as commissioners for the past three years.

The mechanism used to define the issues confronting Nursing in this period was to hold regional public hearings. Five public hearings were held in major cities of

the United States. A small panel of commissioners heard each of those public testimonial presentations. I was sent to a different area of the country away from home where, from early morning until evening, I heard testimony of a long succession of individuals presenting their concerns about nursing. Some of those individuals were practicing nurses, some were hospital industry people, and some of them were nurse educators --- but the subject was always Nursing.

I was overwhelmed by the diverse opinions being voiced. How should nurses be educated? How should they be utilized? How should they be rewarded? What should nurses' relationships be with the other health providers? How should nursing services be organized? The testimony was summarized and published, and can be purchased for $7.00 from the Hospital Research and Educational Trust, 840 North Lake Shore Drive, Chicago, IL, 60611 (American Hospital Association, 1982). The summarized information was brought to the NCN conference table in Chicago. Having heard the diversity and intensity of opinion the non-nurse commissioners in all honest and integrity turned to the nurse members of the Commission and said "Tell us again what is it that you need?" The response clearly indicated the nurses on the Commission were colleagues but representing various organizations with various points of view.

The need for more meaningful rewards for nursing was not denied. Nursing service organizations were seen as deserving to have participative management, and we agreed that the Director of Nursing ought to participate in decision-making at board-level. However, when it came to nursing utilization we started to have difficulty articulating our own professional point of view. We had difficulty in articulating our point of view because we were organizational representatives and sometimes those organizational points of view are in conflict with one another. We were having difficulty with our allegiances to those organizations.

The NCN was able to do its work, however, through straight and honest communication by which we learned to trust each other. We had a sociologist with us pointed out that the dynamics within the Commission were expectional. Because the group process took place through new and open communication we learned to trust each other. By frankly admitting our problems the barriers were reduced, and relationships all became more relaxed and receptive.

Certainly when the non-nurse commissioners hear such widely divergent nursing views, and when administrators hear such divergent views within your hospitals even at the nursing unit level, it does affect our working conditions and conditions in educational institutions. Professional disunity is a serious problem among nurses. The final NCN report will speak to the issue of disunity in nursing which extends throughout the health care industry. The report will include a very clear statement that the lack of trust in the clinical ability of qualified nurses relates to the diversity in nursing education--resulting in a wide range of clinical abilitities with no mechanism to differentiate between nurses of different educational backgrounds. So the effect of this distrust is coming through in the NCN report.

Nursing and Nursing Education: The Institute of Medicine's Study

Concurrent with the NCN study was the Institute of Medicine (IOM) study. The IOM study was financed by the federal government and mandated by Public Law 96-76 as an amendment to the Nurse Training Act of 1979. The purpose of the IOM study was different from that of the commission. It was intended to determine if continued federal funding was required for support of nursing education; to discover why nurses did not serve in underserved areas; and the like. Some of the commissioners of the NCN also served on the IOM study panel; and the representative IOM members sat in on the commission's meeting. Not surprisingly, the recommendations of the two studies are very much alike. For example, the seventh IOM recommendation calls for closer collaboration between educators and nurses who provide service as being essential to give graduates an appropriate balance of academic and clinical practice perspectives and skills during their preparation. In this same narrative, the IOM report speaks of the need for reconciliation of the differences between practice and education for expectations and goals.

The NCN and the IOM studies call our attention to the fact that nurses have difficulty trusting each other in public as well as in private. This truly is an intra-professional matter highlighted in both of the studies. For nurses and the health care industry our disunity is, indeed, a problem. Some healthy skepticism may be needed for growth, but we need not draw battlelines when we differ.

It is obvious that we here share a concern about the need to build trust or this room would not be as filled as it is with the disguished people who are here, and an organization like MAIN would not present this subject for its conference. And had it not been for the positive aspects of nursing over all its many years, an alternative to nursing care probably would have been found by this time. At one time when the NCN was deep in deliberation it semed to them that if nurses couldn't agree to work together that another alternative might be found to nurse patients in hospitals. Lucky for us no one has yet found an alternative for nursing. We may talk about our mistrust, but we also have a lot of trust too, in the present evolution of a very satisfying profession.

Magnet Hospital

Another study, called "Magnet Hospitals - Attraction and retention of professional nurses" (American Academy of Nursing, 1983) provides current data on the most effective structure for our organized departments of nursing as indicated by retention and job satisfaction of the nurses. The NCN has also published a report titled: "Nursing in Transition: Models for successful organizational change." It described thirty very successful nursing organizations having attributes that make them successful and trustful environments.

The risks of not having a cohesive, trustful nursing environment are obvious -- reduction in our numbers and reduced quality. The rewards of having and promoting a trustful environment are seen in success and excellence in practice, excellence in education, and the conjoining of the two for new levels of professionalism, greater concensus on important issues, greater effectiveness, and increased number of talented professionals entering nursing.

Shared Governance - Management tool for building trust

One of things that helps to improve trust relationships in organized departments of nursing is shared governance. Shared governance is still not well defined at this time. The Commission was not able to define a shared governance model because it seems to be more a concept at the present time than it is a defined set of ideas. Nevertheless, I have had rewarding experiences in three working environments in which shared governance was operating. One structural component of shared governance is a Professional Nursing Practice Council, through which staff nurses can

participate in the management of the entire department. Through the Nursing Practice Council staff nurses may give advice to nursing administrators on practice matters which concern them. It is a vehicle for communication that flows both ways. The nursing executive is given an ample opportunity to educate (and be educated) through these informal discussions. Institutional and professional philosophy can be clarified and ethical issues resolved, or at leat aired with better understanding. The staff members of the Council then share communications and interpretations with their co-workers. Free flowing and honest communication has been extremely helpful to both staff and administration. The nursing administrator is benefitted through increased awareness of staff issues and interpretation of goals.

Each staff has a representative group to which he or she is responsible both for receiving input to be presented to the Council, and to whom he or she carries back the information from the Council on the organization. At Sioux Valley Hospital, we began our shared governance with revision of the dress code -- an issue that is non-divisive because nurses are never happy with the dress code. Once we had used the process successfully we, moved on to practice matters such as policy for IV's, and what the clinical competence level for performing IV therapy ought to be. The staff nurses create policy statements and make their recommendations to the nursing administrator, his or her job much easier. It gives the staff a true sense of involvement and considerably reduces the mistrust that traditionally occurs between nursing administrators and the staff.

Conjoint efforts of nursing service and education

In addition to shared governance in organized departments of nursing the conjoining of nursing service and nursing education is becoming an essential link to better patient care. Myrtle K. Aydelotte who is no stranger to you, helped with the IOM and the Commission studies by writing a paper on this topic. (Aydelotte, 1982).

In her paper, Aydelotte states that until conjoining occurs graduates will not be prepared as they should be for the realities of practice in their profession; and nursing service administrators will not be able to use the knowledge and skills of graduates as they should be to maximize service benefits. Conjoining can mean a lot of things. We did much analysis of word-meaning in the Commission until we found words that did not have emotional loading for one

group or another. The word "collaboration" caused serious problems for representatives of the medical profession. So we stopped talking about "collaboration" and used the term "working together" instead. We were surprised at how much better the discussions became. Thereafter, the commission talked about "working together" "collaboration" was not used.

"Conjoining" means creating an organizational structure that promotes functional conjoining and/or systematic interaction between the academic nurse and the nurse in practice settings. It may mean collaborative financing of nursing education. It may mean ways to facilitate faculty practice. It may mean clinical experiences for nursing students with adequate faculty supervision and supervision from qualified individuals in the practice setting. And, it can mean various ways that the transition from education to service is facilitated. It can mean any of all of these things, some of which are described in the IOM report, and how some of those things can be achieved. Common goals and standards improve patient care. There are some risks associated with conjoining that make us a bit nervous; for with conjoining there seems to be an overload on some select staff. Also there may be conflict over interpretation of arguments and disputes, and particularly over which conjoint member is responsible for the <u>improvements</u> that occur!

A fine example of conjoining is evidenced in the document titled "Preparing the Nurse for R.N. Licensure and Employment in South Dakota." In it the nurse educators and the nursing service personnel got together to agree on the skills expected of new graduates and required at first level positions. Together, conjoined, they made efforts to merge those two points of view which was reflected in that very helpful document. It is one of the best products exemplifying conjoint process that I know of.

Mentor relationships

A third avenue by which trust may be developed is through mentoring. Mentoring used to be thought of as a relationship situation. Now, however, mentoring is defined as a formal program. Even so, mentoring is based on a relationship which implies practical, usually advanced-level teaching and learning by means of role modelling. Within our professional ranks we do not have a good record for taking care of our professionally young at the nursing unit level. Professionally mature nurses may see themselves as different; or be a little shy of befriending, assisting, or

teaching the less experienced nurse; perhaps because of the differences in age, preparation, and experience. Notwithstanding, nurse educators and senior nurse executives could bridge the gaps through a change of attitute. With the right group of willing nurses working together with the nurse executive, positive communication and trusting relationships can be built.

One of the truly rewarding components of a long professional career can be the nurturing of the less experienced -- watching them grow, helping them succeed. Even talking through the various ways that a task can be done - one on one - is productive; and some of this can be done without the need for a formalized or structured program.

The biggest burden is on the shoulders of the nursing service administrator to change the mistrusting pereceptions between older and younger, professionally experienced individuals.

The national nursing organizations, throughout our history, have provided a center for professional identity and growth. They have also been a source of dysfunctional distrust within the profession; not by deliberate design, but as an unlooked-for consequence. The American Nurses Association, The National Leaque for Nursing, The Federation of Specialty Organizations and The American Society of Nursing Service Administrators have each championed their own cause and competed for membership from the same population. Efforts toward organizational survival are built upon providing strong programs for their members; and these efforts may periodically lead the organization to take different positions on the same issue.

Whatever organization a nurse may join, all nurses must begin to talk together in a different way by seeking, and giving, support for their positions from one another.

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PANEL: Promoting trust - What works?

Panelists

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"Hospital-Community Nursing Service Relationships"
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"Nursing staff organization - format for building trust"
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"Trust relationships in academic setting"
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"Cultural dimensions of trust"
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The assignment for panelists was to suggest, from their professional vantage point, the attitudes and behaviors that could best bring about trusting relationships in the work environment; and especially in areas where mistrust is known to be a chronic, endemic problem.

HOSPITAL-COMMUNITY NURSING SERVICE RELATIONSHIPS

by Ellen Elsbury, M.B.A.
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A friend of mine told me a story of a woman who was stalled at the intersection, unable to start her car. The light changed from red to green and then back to red. In back of her an impatient motorist began honking her horn. Finally the woman got out of her car, walked back to the other driver and calmly said, "If you will get my car started, I'll be glad to keep honking your horn for you!"

Nursing service administrators may have a tendency to sit back, honk their horns and find fault or criticize. However, I believe that now is the time to separate the "car fixers" from the "horn honkers." Many of us need to become visible in decision making through relationships of acceptance, honesty and trust. If we do not work together to develop solutions to health care issues and to determine the nurses role then someone else will do it for us.

Issues Challenging Nursing Service

The health care industry is being confronted by multiple issues such as the Tax Equity and Fiscal Responsibility Act, diagnosis related and prospective reimbursement systems, health maintenance and preferred provider organizations, utilization review, business coalitions and super health care systems. These issues are centered around cost, price, competition, and market share campaigns, not quality of patient care.

Because of these issues, nursing service administrators are being challenged by a mix of more severely-ill patients, reduced revenue projections, additional demands for home health care, lean and mean boards with professional trustees, productivity standards for staffing, and a lack of funding for patient education. Other developments that need to be dealt with are clinical ladders, polarized nursing groups, entry-level qualifications, and an increase in the elderly population. Nursing service administrators are being asked to reduce their capacity to move forward, exactly when they cannot afford to stand still.

Evolving Indicators of Mistrust

In an age of such intense competition for both business and professional progress "mutual suspicion" and fear have replaced "mutual trust." The nursing service administrator is often guided by a Machiavellian or "outwitting the other" attitude. Communication, both as sent and as received, is filtered, biased, distorted, apathetic, defensive, suspicious, hostile, reactive, and possessive as to turf. Management by crisis is diverting energy and creativity.

Within groups of nursing service administrators many of us lack unification and common mutual goals by hanging on to old ideas and by developing "war strategies" to win the conflict. These groups often seize expedient solutions as a device to quickly dissolve, or to end the work at hand, and are competitive to the point of destruction.

If mistrust continues to erode relationships, unfavorable trends will begin to be manifest in a more concerted effort to restrict the quality and continuity of patient care, duplication of services, and an unfavorable shift in patient loyalty. The participation of nursing service administrators in any nursing organization or effort external to the immediate job will decrease and personal motivation will be smothered.

Becoming Healthcare-Oriented

For hospital and community nursing services to survive and evolve positively, many nursing service administrators need to reorganize their thinking and the elements of the system of which they are a part or with which they interact. Survival depends on whether philosophies are centered on a lone environment, such as being hospital-oriented or community-oriented, or are expanded outside of existing bases and control to being healthcare-oriented.

I believe nursing service administrators can display a greater sensitivity and responsiveness to all intervening variables within the environment by becoming health-care-oriented. This allows for recognition that all aspects of patient care are a part of the health care system.

Realizing Trust Through A Nursing Service Coalition

Because many decisions or series of decisions are interdependent today, forging a plan of action should naturally become a group effort. A group, through meaning-

ful collaboration with counterparts or peers, can influence the larger system better than the lone individual.

First is the importance of encouraging the development of a strong coalition of nursing service administrators within a local community who have criss-crossing interests with the common objectives of developing the nursing profession and maintaining quality patient care. The nursing service administrators invited to attend can be from hospitals, nursing homes, community health agencies, ambulatory services, related health care organizations, and industry. To have a strong coalition, it's imperative to include the expertise and involvement of those people who will put programs into action.

Potential problems. We have, of course, to be cognizant of the dangers in which a group of this diversity and influence may be threatening and unproductive. A few of these conceivable problems are:

- unrealistic goals with a conflict of interest;
- suggestions not kept in balance;
- manipulation;
- feelings that are too intense;
- great promises but little action;
- exaggerated and distorted information;
- urgent crisis-oriented problems being addressed, not important ones;
- win-lose situations;
- command-obey relationships;
- abrupt, high-pressure projects; and
- no communication at all.

Managerial techniques. Hospital nursing service administrators, as catalysts for this coalition, need to develop sound managerial and behavioral techniques regarding change and group interaction that will build a trusting relationship. It is necessary to:

- select a neutral place to meet;
- provide conditions which stimulate members to make full use of their abilities and to grow to their full potential, and which give each person a sense of achievement and personal worth;
- encourage a stable membership to elicit group loyalty;
- urge a high degree of open communication with sharing of attitudes, perceptions, needs, and wants;
- offer current, correct and valid information and base corrective actions on this information;

- tell others what we are interested in knowing;
- give each member personal responsibility for resolving some of the issues;
- offer help only when the recipients ask for it;
- be businesslike in nature;
- utilize task forces with linkages whose disciplinary membership is of a variety comparable to the projects variety;
- set common goals that are recognized by all members through collaboration that are future oriented, will provide for the continuity and improvement of patient care, and will focus on clincial practice and the development of the nursing profession;
- recommend a procedure for periodic assessment of the group; and
- set up a telephone network for communication.

Recommended coalition projects. I propose the coalition address concepts to facilitate the relationship between nurses and to provide a cohesive unit for planning and providing quality patient care. These concepts, perceived as important by each member, are developed into individual projects.

The first project I advocate is an exchange program for head nurses and community health nurses where both become aware of the need for continuity of care through discharge planning. Head nurses make home visits, evaluate the hospital's patient education program and learn what the community health nurse has to offer. The community health nurses learn how to follow through and reinforce the hospital's patient education program, become sensitive to hospital constraints, and provide for positive feedback into patient care conferences. Other projects to be considered are:

- jointly established public education programs;
- establishment of clinical practice standards with emphasis on research;
- joint patient care conferences;
- formation of collaborative community nursing centers or neighborhood nurse offices;
- development of alike nursing care documentation forms;
- management seminars to create methods in which nursing service administrators can research ways to develop revenue and cost centered budgets;
- physical assessment classes for all nurses; and

- task forces zeroing in on the care of the elderly, disabled, children, and so forth.

Trust and acceptance will emerge slowly as the coalition learns to share positive and negative feelings without reciprocation. The results are a raised self-concept, enhancement of public trust, continuity of quality patient care, and a reassertion of confidence in our professional values.

Conclusion

There are a lot of "horn honkers" in this world, but there are very few who will get out and get the car started. Nursing service administrators can take up the gauntlet to effect a win-win situation within the health care industry. To lead we must act by going out ourselves and joining our hospital associations, nurses associations and alliances, and by forming coalitions, colloquiums, consortiums and relationships which promote trust and acceptance of the nurse's role within the health care system.

NURSING STAFF ORGANIZATION - FORMAT FOR BUILDING TRUST

by Margretha Rohlfing, RN, BA
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I was in education for fifteen years in Portland, Oregon. Then my family moved back to Madison, Wisconsin, and out of necessity I had to go into nursing and became a psychiatric nurse. In the last six years my image of nursing has changed considerably, and after this morning's messages I am proud to be a part of the nursing profession.

From an experiential perspective I have observed the following considerations and resulting behaviors in myself and others when our trust in each other and/or administration had reached a low ebb. My first experience of a low trust level was when I worked in a state mental health institute. I learned quickly that the administrative philosophy was one of hierarchal control. When I made attempts to get the supervisors to include staff nurses in team planning and decision-making we were told in no uncertain terms by the unit director, a psychologist, that we could voice our opinions, but the final decisions, policy, and treatment plans would be formed by management. The results of this parental, authoritarian treatment of staff nurses were that we lost interest in our nursing care programs, and our initiative diminished to the point that we just went about our tasks in robot-like fashion, frequently using our breaks to complain about the system and to critize the staff that represented that system. Nurses took sides for or against management and we soon found ourselves getting paranoid about who we could trust among our peers and who was in management's camp.

Another example of a negative trust experience happened about three years ago at Methodist Hospital where I am presently employed. The nursing administrator at that time told us to reconstruct the functions and organization of our whole unit. She said to "dream big dreams -- the sky was the limit -- let our fantasies go wild and create an ideal unit." So a core of our staff did just that. They wrote up a program that would change our general psychiatric unit to an adolescent drug treatment center. Unfortunately that administrator left without doing anything about those dreams, and our new administrator, Marlys Peterson, arrived on the scene faced with the reality that promises had been made by the former director which were far more grandiose than the system could honor.

When staff was given this information a wave of rage swept through the unit. Bitterness and cynicism were expressed among staff both at the nursing stations and in the staff lounge. Staff investment in patient care diminished. An increasing amount of time was spent behind the desk with minimal attention given to patients and therapy groups. The attitude was so negative it was even reflected in the sloppy clothes worn by the nurses -- patched jeans and sweat shirts. (Uniforms were never required on our unit.)

The nurses even brought in their knitting and they worked on cross-word puzzles and other exra-curricular activites on duty time, even including selling Mary Kay cosmetics. Staff splitting developed and scape-goating of the head nurse and the administrator became a favorite pastime. The atmosphere was charged with negative hostility. Nurses were taking more sick days and LOA's. I personally was torn between frustration with management and resentment toward the staff who were not sharing the work load. Finally, last August eight of these staff were fired, and the other disillusioned staff found jobs elsewhere.* A whole new staff of nurses have now been hired and we are starting with a cleaner slate. We are now moving to a more positive experience in trust.

*These eight were nursing assistants and we were switching to an all professional RN staff.

Marlys Peterson, our new nursing director, presented a program of self governance to our hospital. It was based on the structure of a nursing council made up of representatives from each unit. At first there was considerable resistance because nurses are used to being told what to do -- so used to being told that we had trouble believing that the time and energy spent on the nursing council program would really result in self governance, rather than just be a fancy mouthpiece for administration. However, we have discovered especially in the last year, that self governance is a reality at Methodist. There is a new atmosphere of trust that is beginning to evolve between staff and administration. On our psychiatric unit for instance, we are experimenting with a professional nurse model. A management team made up of five of our staff nurses who divide the responsibilities of our former head nurse. This system provides for greater autonomy and independence in our work environment. It has motivated all of us to take more pride in our professional responsibilities. With the encouragement and facilitation of an excellent clinical nurse specialist we have rewritten our unit philosophy and policies and have developed an exciting new adjunctive model

treatment program in which all the staff participate. The atmosphere on our units is far more positive, trusting, and charged with creative energy than it has ever been.

The factors which contributed toward trust between staff and administration in the last year are these:

1) Our new administrator was dynamic, assertive and enthusiastic. She presented herself in such a way that we believed she knew what she wanted, and where she was going, and that she had the ability to get there. She gave us belief in ourselves that we could be somebody, that we were professionals, and we had the capabilities to move ahead with a new program. She offered us some exciting challenges, along with patience and encouragement whenever we became doubtful and negative. She set aside the old parental authoritarian management style, treated us as professional colleagues and offered us the opportunity to participate in the decision-making process of our environment. This 'owning' of our environment and being responsible for it has reduced the old we/they concept we had of staff and administration. Marlys, our Director of Nursing, attends our weekly staff meetings, listens to our complaints and concerns, and facilitates the necessary changes. She actually makes changes on our behalf. I couldn't believe it. Our expression of feelings and opinions (and believe me we are a very assertive group and don't hesitate to express our feelings and frustrations), are not censored. There is no disciplinary action given because of them. Our director holds open office hours and makes herself highly visible and available to staff. Her frequent affirmations and enthusiasm about our unit have greatly improved our staff morale.

2) Our Clinical nurse specialist has also contributed to staff trust. She has worked all three shifts and weekends and holidays with us, and, believe me, as a staff nurse that carries a lot of weight. She fought for and won the right to exclude our medical director from our nursing care conferences, so that we nurses could do our own assessing of patient needs and develop programs without being intimidated by his remarks, often sarcastic. She has helped facilitate the developing of our new program with the patients. She constantly affirms and encourages us as individuals whenever we demonstrate professional excellence. She is

very supporting and nurturing at the same time she challenges us to be our professional best.

All these behaviors have served to increase our trust in management and administration.

Now to look at the conditions which seem to enhance trust, staff to staff.

Assertive communication is one of the most important classes that is taught on our unit, to our patients. It is the essence of our unit philosophy.

We practice being open and honest and communicating directly with each other as a staff also. I don't mean to pretend that we do it all the time, but we really do make honest attempts in that direction.

We also have a communication book in which we share feelings and opinions, both positive and negative, and constructive criticism. We have a nursing support group that meets weekly to share feelings of anger, inadequacy, anxiety, and hurt. We frequently shed a few tears, and work through personal conflicts. We are not afraid to make ourselves vulnerable with one another. We do a lot of hugging, both verbally and physically to build each other up. We work (and this is the area in which we need the most effort and most improvement) at respecting individual differences in values, personalities, skills, and idiosyncratic behavior. That is a power-loaded goal to stop value-judging, to allow others to be different from ourselves, and to agree to disagree. Whenever I teach conflict resolution I am constantly emphasizing negotiating skills and I feel our staff works hard at this.

I want to talk about support groups because our last speaker mentioned "new nurses entering the work place." Something that developed out of our nursing education program was a support group for new graduate nurses which I have the privilege of facilitating. Because I am a neutral person in this group I am not related to their educational department, I am not related to their head nurse, so they can safely come and share their frustrations and their feelings of inadequacy with me. In turn, I teach them positive self esteem, conflict resolution, assertiveness, and cooperation. They air all their differences forming a sorority in support of one another. We even helped one new nurse who, after she joined our staff, found out that her fiancee was dying of cancer. Whether the problems are professional or personal this group has proved very effective

in helping the new graduate nurses avoid, or at least cushion, reality shock, and begin to trust their hospital and develop the feeling that their employee cares about them as human beings. These are the things that we try to promote in Graduate Nurse Support Group.

On our unit we are dedicated to a philosophy of team work. There is no doubt that we are a team, and that there is a genuine commitment to each other and the unit. There is no feeling that I am aware of, of competition among us. We have morning meetings every single day except the weekends. In these we work together as a team, and is that ever a great feeling! I don't mean to imply that we have a utopia by any means, but in looking at the overall picture and comparing it to other institutions where I have worked, including hospitals, churches, and schools, I believe the psychiatric unit at Methodist Hospital in Madison, Wisconsin, is one of the healthist environments in which I have ever worked. The trust level has increased 100% in the last year with our new staff-owned environment program.

TRUST RELATIONSHIPS IN ACADEMIC SETTINGS

by Mary Wakefield-Fisher
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I would like to share with you some very concrete, basic pieces of information that have helped me become more effective within a structured complex organization, as both teacher and manager.

Although I am new to management, I assumed the role of an area coordinator one year ago, which is akin to a department chair, but does not have quite the same responsibilities. The role is certainly ambiguous in some respects. In general, however, to fulfill that role I must be 30% manager, and 70% teacher, researcher, and service provider. In this position I must articulate effectively with a number of groups made up of people with common concerns. The purpose of this presentation is to highlight basic elements which characterize my interactions with those groups and which serve to maintain trusting relationships.

The first group with whom I must articulate effectively are my fellow area coordinaters. I am one of five area coordinators in our college. The title "coordinator" buys admission to the group, but entry into the group does not automatically mean you will work with them effectively. It took me a year to establish comfortable relationships.

I would like to share with you one problem that I see in my own articulation with that group and perhaps some of you share it in some sense in your own agencies. I find that in my interaction with the other area coordinators, my peers, I have a perception that we do not share problems with each other in the most useful way all of the time. Now let me try to step back and explain that.

If an individual area coordinator has a problem with area faculty, with students, or with administration, typically those problems are not brought to the group of area coordinators for discussion. We attempt to manage such problems, even though they are community problems shared by all of us, by going to an individual's area coordinator whom we trust, for a one-to-one discussion. For some reason this approach seems safer, and we are able to trust each other more in that one-to-one situation than in a group of four or five people. Logic tells me that I could be better helped

in solving my problems if I could draw on the expertise of four or five individuals helping me simultaneously to solve a particular problem. However, we are not at that point, so I have attempted to use certain strategies to allow us to communicate more comfortably with one another when we are faced with problems that are similar for all of us.

First, I have used self disclosure so that when I am with those groups I identify some of the problems that I am faced with. Now that might sound simple to do, but when you identify your problems or difficulities among your peers you may wonder how well that will be received. Clearly, this is a risk-taking approach. But self disclosure is like opening a door -- if people perceive that I seem comfortable in sharing concerns with them, they will reciprocate and, in turn, will become more comfortable sharing their problems and ideas for solutions with me. So taking a first step toward self disclosure may be an important one. If other individual area coordinators then share with me, I in turn can share my expertise and be supportive to them. I try to readily share as much information to assist them in solving their problems as I can to promote an open healthy environment among colleagues. And, while I think we all do that some of the time, we do not do it as often or as effectively as we could because of the risks that we might have to take. I encourage self disclosure and supporting rather than competing with colleagues and say this with confidence perhaps because to this point I have not had my fingers burned by taking such risks.

Other interactions that I have had in terms of promoting trust in an academic situation is in interacting with students in my role as area coordinator. The interactions that I have with students often spill over and affect my interactions with other groups, so if I interact inappropriately with a group of students it will come back to haunt me through my faculty colleagues or through my administrative role, therefore, I am particularly careful about my dealings with groups of students. Let me share some examples of the problems a relationship tainted with mistrust can produce, when faculty interact with students.

Sometimes, in academic settings, faculty are pitted against each other by manipulative students. A student might come to one faculty member or to an area coordinator to express some serious concern about the way another instructor is teaching, and that may result in problems. Students confiding to one faculty member that they are having problems with another faculty member results in a sense of

distrust and paranoia among faculty who begin to wonder what comments are made behind their backs and with whom students are discussing their concerns.

A recommendation for averting this situation is to send students back to the source of their conflict and encourage other faculty to do the same. The fewer the number of people involved in the conflict the easier it is to resolve.

However, if, a student does go back to the faculty member with whom a particular problem originated, and the problem is not solved, then I encourage the student to come back and discuss it further with me. The area coordinator then, becomes a second level of problem-solving. When a student comes back to me because of dissatisfaction with previous attempts to resolve the issue I make a real effort to get all of the relevant information and perceptions about the problem -- from the instructor, the student, and relevant others. This consistent matter-of-fact approach to problem-solving promotes trust between me and my area faculty, and between students and faculty because it demonstrates follow-through when problems arise and the mechanism for follow-through does not change.

Given the protocols that we have within our institution I am able to make decisions so that if, an instructor has one perception of a problem with a student, and the student has another perception of a problem, resolution may well flow from a decision I make as area coordinator. It may be perceived as favorable or unfavorable to either or both parties. However, my faculty and students can always trust that a decision will be made at this second. I also advise other faculty in my area that if they are aware of complaints by students about another faculty member that they, too, should send students back to the faculty member with whom they have a problem. In this way we have built a sense of trust in terms of how we operate on a day-to-day basis with students' concerns. Although this might sound fairly simple to you, I think sometimes faculty may be too sensitive to students' concerns, entertaining the students' vocalization of problems and complaints rather than sending the student back to the source.

Similarly, a dean, or another manager, may discuss problems with one group of faculty when the problem more directly relates to another group of faculty. The cardinal rule that should never be broken is to confine the discussion of a problem with the faculty group that it involves instead of discussing the problem with others. Although we are probably all aware that we should refrain from discuss

ing an individual's or groups' problems with somebody else, that misguided action does occur. Nothing erodes trust in an organization as quickly as a manager discussing one groups' problems with another group. Even well educated seasoned individuals are guilty of this destructive behavior at times. Trust in this kind of environment simply cannot exist.

When problems and concerns are presented to the appropriate person or group I prefer, at least initially verbal dialogue with faculty or students. I tend not to want to begin resolution of a concern by putting that concern in writing, at least not initially. Verbal dialogue allows me the opportunity to avoid having to second guess or read between lines which may result when communication is expressed in written form. Verbal dialogue allows a better sense that the underlying intentions of both parties are being exchanged and understood. We can begin to establish a sense of trust in the idea that through dialogue we may achieve a common understanding of the concerns being discussed. Informal verbal dialogue may help to clarify and establish trust, often better than a written message.

Another strategy which I find promotes trust is to hold frequent informal meetings with faculty and students. If I meet in their office, an area where they feel most comfortable, I demonstrate that I trust their acceptance of me, and show them that I care to take the time and/or have a need for consultation with them. Meeting with them informally, often allows us an opportunity to trouble shoot, or to clear up miscommunications without ever having to bring a problem into a more formal meeting. I believe that keeping in touch through informal meetings and dialogue with both students and faculty is much more important than it may appear and helps to keep us all feeling more assured and comfortable because we feel we are keeping in touch with concerns at student faculty and administrative levels. There is nothing worse than the feeling that you do not know what is going on in your own house, yet it can easily happen.

In assuming the area coordinator position a year ago, I established some objectives for myself: In my role as area coordinator I wanted to become more efficient, trustworthy, human, supportive, and knowledgeable. Without attempting to achieve growth in each one of these areas my work could easily take on the characteristic of survival rather than continuing growth.

We need to be reminded that basic principles of good communication, supportive attitudes toward our colleagues and students are gifts we can afford to give each other. Building trust does not have to be a complex process. It begins with very simple steps.

CULTURAL DIMENSIONS OF TRUST

by Madonna Beard
Social Problems Specialist
Rapid City Indian Service Council, Inc.
Rapid City, South Dakota

I would like to thank you for giving me this opportunity to talk with you and I have to say that I always get a little thunder struck when I look up and see everybody looking. I think about my husband. He was taking a course in public speaking and one of his classmates got up and said on TV, "Good ladies, morning and gentlemen". I'm always afraid I will do that.

I am here to represent Indian Health Service. Indian Health Service is a branch of the U.S. Public Health Service which services all federally recognized Indians and Alaskan natives. The federal government's responsibility orginates from treaties of past centuries and has been further established through laws enacted by congress.

There are 250 federally recognized Indian tribes and they live for the most part on federal Indian reservations and in small rural communities. The majority of the twenty-five states in which federal Indian reservations are located, are in the western half of the nation.

The Indian and Alaskan native people have in general, maintained much of their traditional culture, and the way they have done this is usually through passive resistance. Some, especially the older people, speak little or no English. They are also among the most impoverished of U.S. people. They are often deprived of such life serving necessities as good nutrition, potable water, and a sanitary environment. My reservation, the Pine Ridge Reservation, is in Shannon County, the poorest county, with the lowest per capita income any where in the United States. The reservations in South Dakota also are among the poorest counties in the United States.

Many of the reservations and communities are located in isolated, rugged areas where climatic conditions can be very harsh. These conditions coupled with the lack of roads can make transportation difficult. In Alaska, for example, there are places where there are no roads and ill or injured people have to be airlifted to health facilities.

Under such conditions, it is not surprising that a number of health-related problems exist in high proportion among Indians and Alaskan Natives. Some of the most serious of these are accidents, alcoholism, mental health problems, otitis media (middle ear disease), mild and severe nutritional deficiencies, and poor dental health. Other major health concerns are maternal and child health needs, unhealthy environmental conditions, and problems associated with aging.

Substantial progress has been made, however, in combatting health problems, especially acute, infectious diseases. For example, from 1955 to 1976 the incidence of tuberculosis was reduced to less than one case in every 1,000, representing a drop of 73 percent. Reductions have also been made in morbidity and mortality rates for other diseases. In the same period (1955-1976), the mortality rate among infants was down 69 percent; and influenza and pneumonia were reduced by 59 percent. Another killer, gastroenteric diseases, has declined by 86 percent since 1955.

The IHS mission is to assure the availability of a comprehensive health service delivery system that will provide Indians and Alaskan Natives opportunities for maximum involvement in defining and meeting their own health needs.

To achieve this, the Indian Health Service has established three major program objectives:

* Deliver the highest quality, comprehensive health services possible, including hospital and ambulatory medical care, preventive and rehabilitative services, and community environmental health programs, among them the construction of individual water and sanitation facilities.

* Assist tribes and Native corporations to develop their capacity to staff and manage health programs, and provide them with every opportunity to assume operational authority for programs, if they so choose.

* Act as the Indian's and Alaskan Native's federal advocate in health-related matters.

Source of distrust

Indian Health Service is a very big organization and that in itself is the basis for some of our distrust among the nurses. It has a hierarchal system in which the national objectives for Indian people are decided in Rockville, Maryland, and the decisions are passed out first to headquarters and then to the service units. Then they are transmitted out into the districts where the nurses work. So the distrust stems from the question: how does the hierarchy know what is best for me at the grass roots level? As a result, there is little ownership of the goals and the problems of the organization at the grass roots level.

Another factor is that the Indian Health Service is composed two kinds of employees: commissioned corps employees who are a part of the Public Health Service system; and civil service employees who usually come from the area in which they serve, and are usually members of the community that receives the services of the Indian Health Service. So the civil service employees have a more vested interest in what happens in that particular unit. The commissioned corps people that come have a greater commitment to a mission or to an organization rather than to the local community. Commissioned corps personnel are assigned on a two- to four-year term in the different reservations; so there is mistrust between commissioned corps and civil service employees.

When commissioned corps people come out to the reservations their housing is built usually in kind of a complex that is away from the village or away from the community so that they live apart. In fact, in Pine Ridge where I am from, they live on a hill and they do not become part of the community. They become a target for the community. Burglars go up there because they have a good income and there is a lot of loot. Sometimes commissioned corps personnel come with little sensitivity training about the people they serve. They are not aware of the people's cultural values. This is not everybody, but I am talking about problems that cause distrust. They have little information about the people's cultural or health practices. An example of that is the code of our people among whom it is considered very disrespectful to stare at, or to look directly at another person. That is considered to be invading their privacy or questioning them. So when an elder or a person in authority talks to you, you do not look directly at them in return. In the dominant culture, what that

means is that you are probably lying. If a person does not make eye contact, they are sneaky or they are not listening.

Another example: it used to have a great deal of importance for our culture to be reticent, to be quiet. Because we were a hunting and gathering society we had to learn to get along well in silence. Many of the reasons for that reticence are now gone, but the cultural value is still there. So when corps people come in they may get really uncomfortable with the silence - the lack of response. Indians are masters at non-verbal communication, and so that causes problems.

The people that are on the reservations have been there most of their lives. They remember that the doctors and many of the professional helpers that come change every two to four years, and some of them come with great messianic ambitions. I can not tell you how many times we have been saved. So we really have a problem with trust under these conditions.

The history of the U.S. government and the Indian tribes' relationship has not been a very good one. People are always kidding me that they are going to report me because in the clearance documents that you have to fill out to get into U.S. civil service jobs, the form asks: Has a member of your family ever tried to overthrow the U.S. government?

One of the great American myths that we Indians have been a victum of, and I believe that you have been too, is the idea of assimilation. Assimilation implies that one way is better, and it is not the Lakota way. It also implies that "what you are is not OK." The spiritual practices and healing practices among our people were historically very interrelated. Our whole world view had more of a spiritual outlook then. And, in 1800 when the government was trying to assimilate us they outlawed the spiritual practices. So a lot of our healing went underground and it was only in 1976 that the Indian Religious Freedom Act was passed so that these things could resurface. Our outlook is a holistic health type of outlook -- we believe we are complex human beings with a spiritual ground, and that illness is an indication of an imbalance. The medical model is more physical and so there is that area of conflict or mistrust. Many of the old people will not come in for health care, preferring to go to their own medicine men. Or they will bring their own medicine and their own pertinent healing herbs with them to the hospital which many

which many people do not understand. They don't know what it means. For example, Indians may bring eagle feathers with them. The feathers have a very important meaning for us and we do not want them sterilized.

Suggestions for developing trust

Some of my suggestions to help cut down on the mistrust and to bridge the gaps in understanding are these: if you are going to work for an ethnic group, find out a little bit about the people whom you will serve. Remember that truth is like a crystal, it has many different facets; and if we think that we have the truth and we are the only ones that have it, then you don't have it. This becomes a situation in which "I am right and you are wrong," and this has been a repeating pattern throughout our history.

Examine your own needs when you go to work with patients. I have a need to know that I am a good teacher and many times I will hammer away at people, asking them repeatedly - do you understand? Remember that my concept for what is best for you may be very different from yours.

We have talked alot about respecting another person's choice; and that same principle applies to health care, too. Remember that the choice for health rests with the individual. For example, we study infection in nursing - and talk about the chain of infection, but I think we don't put enough importance on the resistance or susceptibility of the host. And, so when people come to us, all we can do is offer our best and let them choose what they will use. Some of the symptoms of mistrust are isolation, suspicious, paranoid behavior; stock-piling; i.e. counting how many friends I have on "my side", or how many of us are dedicated to the hospital and curative nursing, versus preventive health; amassing power, rigid outlook and defensiveness. These attitudes and behaviors may be manifested in any department that you can enter. I think of a modern day classic example when I think of Russia and the United States stock-piling nuclear arms, competing to be the one who has the most. We are urged to cut out nutrition programs and get more rockets. Remember that trust is a choice, and it starts within each of us. It is a conscious decision to take a risk, and a willingness to share. Real leaders do not create dependencies. Good nurses do not create dependencies. They show people their own strengths.

Moderator:

Thank you Madonna.

I really can not say anything after that. I had some summary remarks, but I think that Madonna has summarized the whole day very beautifully. Does anyone have questions for the panelists at this time?

Question:

I would like to direct a question to Marge Rohlfing. You were talking about the dissonance that you encountered - the dissonance within your unit, and how angry your people were and how they didn't allow themselves to embrace these new ideas that the director had presented. How did you overcome that?

Answer:

We didn't. We ended up having to fire them.

Question:

You said you hired new people and even the new people were very distrustful and very hesitant to undertake any of these new concepts so how did you go about circumventing that?

I think that Marlys Peterson, who was really working with them, could answer that better.

Marlys:

I can just tell you that at the time that we terminated employees, we terminated employees not simply because they were not cooperating with the program - I want to make that very clear. We changed the staffing mix on the unit to an all-professional staff and laid off the mental health workers, so that was one issue.

The second issue was that we were left with about 50% of the staff that had been on the unit who were, in fact, not only as distrustful as before but now even more distrustful because we had changed the program without their involvement. So I have to be very honest and tell you that it was difficult. The thing that I did was to spend large amounts of time on the unit dialoguing with the staff initially after the mental health workers were laid off. I set up individual meetings with each of the staff to discuss with them what their professional goals were, how they

would like to see the unit move, what kinds of activities they would like to be involved in, and to give them my commitment as a professional colleague to help support them in whatever way I could, and to understand that I know it was very difficult from their perspective.

Question:

I just have a question about competition. I have heard the word "competition" mentioned by several speakers with a very negative connotation, and I'm wondering: what is it about competition that makes it so negative and how could we make it become more positive? I think of the word 'politics' and how in the past nurses were afraid to use the word 'politics'. It doesn't have to be a negative word. Competition is there and you have to learn to exist with competion. Why is that so bad?

Answer:

I think that, from my perspective anyway, the negative part of competition is the part that says that I am better than you are and that my idea is the only idea - it's the only right way, and that I'm doing what I can to be best. Competition can mean egocentricity. If you were talking about supporting one another to become the best that we all can be together, then I think that is the positive side of competition. Competion involves some struggling, one on one, and I see that as being destructive.

Comment:

If I understand the basic problem and the difficulty for nursing, competition comes from marketing approaches so that when you market your hospital you subject yourself to varying kinds consumer preferences and it is projected that some of those consumer preferences may be counter to what nursing believes is warranted; or it may require a reshifting of the priorities of needed services and programs as defined by nursing, to coincide with the priorities of marketing and analysis, which is necessary if one is going to compete. That is where I see conflict, in the choice between two desired goals. I think that is being described in the litature right now and I can sympathize with that.

Comment:

Competition can be negative if it leads us to hoard information, to fail to share information that will improve the care of patients. For example, if I am in competition with you, either institutionally or personally, on a pri-

vate practice matter, I will not share with you my better development, my better model, or my better method. If this had been the case, let's say when Elizabeth Kenney discovered how to treat polio victims, she would have had, and not shared, her Elizabeth Kenney method exclusively. Only if you came to Australia, only in her area would patients have received this treatment. If you are an entrepreneur, you don't publish, you don't speak about it, you don't share it, and then you charge for it. That is the business way. But it is not the professional's way. This is what I call negative competition. Competition in the sense that it can spur one to better things is a good thing; but it has to be very carefully handled within the context of a profession.

BUILDING TRUST RELATIONSHIPS
CAUCUS GROUP DISCUSSION REPORTS

Caucus groups are a MAIN tradition by which the region's nurses can sound out ideas related to the program theme and reach consensus on solutions to nursing care problems in their own settings and throughout the region.

Each Caucus group is composed half of nursing service nurses and half of nursing educators so that discussions benefit from the broadest perspective. Guidelines for caucuses have been developed as follows:

Definition of a caucus: A meeting of a party or a faction to decide policy.

Format: Typically, caucus groups are composed of approximately 15-30 participants. The role of the leader is primarily to facilitate group discussion. A recorder is also selected to document important aspects of the discussion. It is suggested that the group leader meet briefly with the recorder at the end of the session to compare/combine perceptions of ideas produced in the caucus. A summary of the ideas generated by the caucus will then be presented by the recorder to the entire conference group.

The following are recommendations to help facilitate group process.

1. In preparation, the leader identifies two or three "discussion-generating", open-ended questions related to the topic.

2. Two desirable ground rules to establish are:

   A. participants' comments will be most helpful if they adhere to the identified problem and are not emotional reactions; and

   B. participants' comments will be most helpful if comments are not demeaning.

3. Delineate/discuss the problem including relevant history related to the problem. The use of Nominal Group Process* may help to solicit all members' ideas.

4. Identify strategies for decreasing or eliminating the problem.

5. There are two recommended communication techniques which should help to facilitate group process:

   A. paraphrasing - for clarity, periodically use newer and fewer words to recap the basic content of participants' comments;

   B. summarizing - feed back to the group the general substance of the discussion. Attempt to unify a number of pieces of information into main themes or content. Highlight the significant data.

6. Be the time keeper or delegate that responsibility to make sure that some time is allowed for closure with the group.

*A variation of the Delphi Technique for soliciting and combining opinions of a group of experts. Time-limited, creative solutions to a defined problem are solicited (uncritically) from each group member. Then, through reiteration and consensus, the group identifies the best options for solving the problem.

CAUCUS REPORTS

GROUP A: Trust relationships between Staff/Faculty and Administration

Reported by: Kay Broman, University of Iowa, Iowa City, IA

The trust-relationship we addressed was between staff and faculty and administration, with Darleen Sickert as group leader. We started by discussing how to build trust within administration, within faculty, and among peers and staff, but then we decided to focus more generally on the phenomenon of trust.

We prepared a "laundry list" of solutions that we have identified. Each one is briefly worded, but there were a great many of them. Of prime importance, was open communication; and under that we specified two subdivisions: formal and informal -- there would be no hidden agendas. Communication would also be both verbal and written; we would get to know each other; and we would take time to communicate. We would ask for and value the input between faculty and staff. We would build rapport and share goals and objectives. We would demonstrate competence, we would help to orient each other to the setting and the task, we would learn about each other, we would clarify functions, offer assistance, avoid divisive issues, share goals, have mutual respect for peers, and administrators, in both service and education; and we would purvey a sense of caring.

We would balance our personal and professional relationships so that we would give and receive support based on respect. We would respect ourselves and have inherent trust in others. We would facilitate relationships with others based upon identified common ground. We would make it mandatory that promises are kept, and that there is a sense of dependability and reliability in our setting. We would allow time for trust to develop; however, we would take an active stance to initiate trust-building strategies in our setting.

GROUP B: Service and Education in Clinical Research

Reported by: Carolyn Smeltzer, Foster McGaw Hospital
Loyola University Medical Center

Our group discussed possible causes of mistrust between service and education related to nursing research conducted in the clinical setting. We also made recommendations for actions and behaviors that would develop trustful relationships in this situation.

Potential causes of mistrust

The group identified on three causes of mistrust concerning clinical nursing research. Here we were looking at staff nurses' mistrust of research findings.

1. Many times staff nurses do not have the knowledge or the familiarity with the research process in order to value research findings, and that increases likelihood of a mistrustful relationship when developing research projects.

2. Many times staff and others do not have resources available to them, either computer time, budget, or the available personnel, to help them continue research projects. Besides increasing mistrustful relationships, this situation may stifle any budding research interest on the part of staff.

3. Many times research is conducted in the clinical setting and the staff are not aware of the purpose or results of the research; or the research findings are not disseminated to the staff nurses. This causes them to feel "used" without recognition or reward, and may generate mistrust.

Recommendations for building trust

For improving some of these conditions we suggested positive strategies to improve staff relationships with regard to clinical nursing research activities. These were:

1. To explain the applicability and relevance of research findings to the staff nurses with particular emphasis on how it might help in solving patient care problems.

2. Work toward administrative support for released time and resources, including budgetary allocations, for nurses to conduct research in the clinical setting.

3. Work with and involve staff nurses in the research process. An expert nurse researcher could work with each staff nurse interested in conducting research.

4. Develop research projects that are determined to be needs, based on the perceptions of the staff nurses. Let them determine some of the research projects that are going to be done in their clinical setting.

5. Work with staff nurses to develop their skills in evaluating current research to determine which findings may be applicable in their settings. Several hospitals could send nurses to attend research conferences. In order to determine whether the research reported at the conference is applicable in their institution, the nurse who attended could write abstracts of the findings reported at the conferences.

6. The resources of other disciplines should be shared within the nursing community.

7. When research projects are started there should be someone with research expertise 'in house' to guide the research process.

8. The researcher who explains the research project to staff nurses should be someone who is very enthusiastic about the process, and who will increase the trusting relationship.

9. Develop a systematic method to evaluate whether proposed research projects to be implemented in the clinical setting are appropriate in that setting; and have a clearly understood method for letting the would-be researcher know whether that research project was rejected or accepted for a particular clinical setting. Service nurses could offer suggestions to the resercher to make the project more acceptable or effective.

10. Although, this may be repetitious, administrative support, as well as peer support, are vital to the successful implementation of any clinical research project.

GROUP C - Trust Relationships related to Joint Appointments

Reported by: Helen Hansen, Associate Administrator, St Joseph's Hospital, Kansas City, MO.

Concerns surrounding joint appointments

Our group began with a rather general discussion. We tried to identify some of the usual and prevalent concerns about joint appointments. The list includes: having unclear expectations, and the existence of serious conflicts in schedules between the agency and the school. The disparity in salaries between education and service was mentioned as a very prevalent concern when trying to develop and maintain joint appointments. Joint appointees are often victims of the tendency for two part time jobs to become two full time jobs. We noted the difficulty in allocating salary proportions appropriately, such as fringe benefits; and the extra time and travel involved in trying to maintain a joint appointment. The logistics of getting back and forth to each location, the mileage, and the travel-related inconveniences such as parking were mentioned. Unclear contractual relationships were also cited.

These were the primary concerns that were brought out in our group that tend to diminish the effectiveness of a joint appointment, or lead to distrust in the environment around those relationships.

Benefits of joint appointments

The benefits of developing joint appointments include the following:

For faculty --- trust of faculty is enhanced in the eyes of staff in the hospital or the agency. Faculty improve their clinical skills; and in addition, have access to a research setting and the opportunity to market their education skills into the service setting.

For service --- the opportunity is afforded to share service wisdom with education. Service gains access to faculty for consultation and research to help resolve service-related concerns and issues. The reciprocal opportunity is presented to market service skills to education.

We identified some mutual benefits for both service and education such as the development of common values in conceptual models which is something we have done in our agency. We said other benefits included the ability to pool and share resources to achieve common goals; physical

resources, facilities resources, and human resources. There is also the opportunity to enhance professional job satisfaction in both the service and educational setting.

Next we discussed strategies for building two-way trust in joint appointment responsibilities. We identified some that were useful. It is important to utilize legal counsel in the development of contractual relationships between the agencies so that there is clear and legally-based negotiation for all contractual relationships including financial arrangements. Clear assumptions and expectations that may go beyond the legal contract need to be stated. Otherwise there may be misunderstandings based on mistaken assumptions. There should be a published timetable and work schedule for those people who are involved in joint appointments. Finally, there should be a clear delineation of the goals that each organization is attempting to achieve through the joint appointment of the individual, and the rationale underlying the development of the cooperating agencies' joint appointments. Service and education must each develop a plan and take the time to market their strengths to one other.

The individuals fulfilling joint appointments are able to embody the goals of both agencies. There is no substitute for purposeful and thorough planning between both cooperating agencies to establish and clearly outline goals, rationale, and responsibilities for joint appointments, before the joint appointment is made.

GROUP D - Trust relationships between urban and rural health care institutions

Reported by: Jeanine Matt, Director, Palmer Memorial Hospital

Our group discussed trust relationships between the rural and urban health care institutions. I will identify for you quickly some of the problems we felt existed.

The first one was misinterpretation of problems. Perhaps we didn't understand each other. The problems of the urban institution are indeed different from those in rural settings; and the people in the urban institutions do not often understand the nursing problems in the rural setting. We also believe that there is not good communication between the two, or perhaps a lack of feedback between the two institutions with regard to expectations of one another. We discussed predominantly patient care examples; for instance, in the rural setting they do have to have the skills to take care of the trauma patients, the high risk newborns, and so on; but they also need to recognize when they have reached the limit of their capabilities and should transfer the patient for more definitive care. Therefore, we feel the urban hospitals need to give feedback to the rural settings about the things that must be done to prepare patients optimally for transfer.

In return, the urban center should give feedback to the rural community hospital about the helpful and effective things that they have done in preparing the patient transfer. The rural hospital's philosophy, personnel, and patient care capabilities should be known by the health care personnel in urban centers. Each should take time to learn more about the other.

We felt there was a lack of financial resources for programs in the rural setting, that there was also competition for resources and for patients.

There is also a skill level difference between the rural and urban nurses due to the nature of the demands for patient care skills. Skill levels are necessarily more complex if you are working in an urban setting on the urology floor. JoAnne summarized it very well when she said you may have depth in urology, but you do not have breadth in nursing. Perhaps, in the rural setting, you have to have greater breadth in what you do as a nurse because you may be working in the emergency room, and also assisting in the delivery room an hour later. This forces

you to be more compacted in terms of the breadth of nursing knowledge.

Manipulation certainly enhances mistrust and manipulation occurs in administration, in nursing, and among physicians -- or any combination of those three. Because we are all nurses, whether urban or rural, we felt it would be important to create a dialoging situation in which we could discuss mutual expectations. We also believe that one area of solutions lies in determining educational needs honestly. For their part the urban centers should not say: "These are the programs we have to offer. Would you like to select some and we will come out and present them?"; but rather the rural centers should say: (after doing a thorough needs assessment) "This is what we need, what do you have to offer, that can meet this need?" The urban centers could benefit from rural programs to clarify, in more detail, how nursing care delivery differs in the rural setting. Urban nurses could be assigned to rotate to rural agencies for a period of time.

There was a great deal of discussion about networking and mentoring between nurses from the two types of institutions, in which the nurses from the urban centers could come out and spend a day or two in a rural setting and have a truer perspective of rural nursing. In exchange, nurses in the rural setting could go into the urban centers and obtain a much better understanding of the complexity of urban nursing.

A comparsion study of the roles of urban and rural nurses could be done to promote greater understanding of these different roles in nursing and thereby build better trust relationships.

GROUP E: Trust relationships between students and faculty

Reported by: Shirley Davis Martin, Chairman and Professor, William Jewell College, Liberty, MO

Our topic was trust relations between students and faculty. Ours was a small, but very vocal group; so if I do not tell you exactly what was said I am sure they will be glad to correct me.

We identified several problems that contribute to difficulty in student-to-student, faculty-to-faculty, and student-to-faculty relationships; realizing, of course, that administration is obliged to fit in at whatever level may be in trouble, which in itself can be a problem also. I think we are suffering from a tremendous credibility gap that exploded with the Nixon era and has not abated. We are also suffering from lack of clarity on the part of faculty as well as on the part of students. One fundamental question we have trouble dealing with is: Are we colleagues or are we students and faculty? This has been made more unclear with the market place approach to education which has come out of the consumer movement and has made us aware that we must be accountable to people. One of the advantages of a long professional life is that you can look back and see how it was, and know that the past was not all good, but the legalities of our situation today make a great deal of difference in the way students feel about their education and the way educators feel about their education. It makes educators more afraid sometimes to make a statement because they may have to stand up for that statement in court. We have a particular problem in nursing education in that there is no good evaluation tool that is completely objective. When you are called upon the witness stand to testify, and you are asked to back this up, you cannot say "my twenty-five years of professional experience showed me that we were in trouble with this student." You have to provide specific, unequivocal facts to support your statements. So sometimes faculty are afraid to step out on a limb. Students know this, and as much as I love students (I've made my life work working with students) students are very good manipulators and faculty are afraid of this so, therefore, we are divided today into two camps as strongly, if not more strongly, than ever before.

Someone else mentioned a problem today that we identified on the faculty of which I am a part. Last Fall one faculty said: "I let students call me up at night and tell me about problems they see within the program, because some-

body has to listen to the student." The other faculty reacted very strongly because, to me, that was misplaced care for the student. The faculty person should have been directing those comments and those concerns of the student to the faculty involved. What might have been a good intention ended poorly and we have been trying to deal with that ever since. It was not meant to cause a difficult situation for other faculty, but it was a misguided attempt at building trust between faculty and students.

We are also dealing with a situation in which faculty are under constant stress. Nursing has long felt that if nobody else would do it, we would do it; and not only do it, we'd do it well. Therefore, we are constantly prodding ourselves to be good researchers, good educators, good mother figures, good role models, good, good, good, good. So you are sick of being good and always afraid of being caught, and believe me, the students pick up this stress. At the research meeting where I just heard some excellent research we heard that nursing was the most stressed group on campus, -- and that is a suprise to nobody, that is nobody in nursing. You have these sweet neophytes coming in to you as students at age eighteen and nineteen, and 2-4 years later they turn out to be people who are angry and militant, who wonder where the good education went out the window. And you as faculty also wonder where did it go? It came to us that the faculty are so stressed that the students pick it up, and students get it as part of their inherent education that they didn't ask for, but got anyway. One of the things students (and faculty) do learn is to survive; and so you learn to survive with stress. Not all of it is bad of course, but stress it is, none the less, and has to be dealt with. It affects us in many ways. In the academic market grades count for something, and they are seen as something for which students must compete and so students are always competing.

Some of the ways we decided you could address these situations was to give positive feedback to faculty and students. We have probably spent too much time dwelling on what people do not do as we talked this morning. Although I see what students do for a patient, I may mention that they did not do the mouth care; and I comment on that if I am in the unit. I frequent the units so that students do see me, not as an administrator, but as a care giver also. I do not comment necessarily on the good bed they made, the family they comforted, the good charting they did, the bandage they changed. I comment on the mouth care I didn't see given, which they see as a very negative input. We have to be careful to give positive feedback because most

growth will come when somebody feels that you think they are o.k. If you feed that o.k. part of the student they will usually identify the "not o.k." part for themselves, and begin to work on that because most of us are afraid of being found out anyway and we already know where the improvement needs to come. We don't need somebody else shaking a finger at us and pointing it out.

Basically we have to decide, and I think that is probably the most crucial thing, that you are a person of worth whether you are a student or a faculty person; and I have to decide that you are up to some good, not to no good. I trust that what you are about is to help me grow, that you are not here to find me out or to show me up, or to show me how good you are: but that you are here to assist me. When students see that that is the major role of faculty and this is demonstrated to them time and again, then the decision whether or not to work with that faculty will not be a problem when students can work together in groups and identify common goals. One thing we are trying to do at my institution is to institute a pass/fail clinical grade. I see this as a tremendous opportunity for students to be able to practice innovative ideas free from the pressure of being graded all the time in the clinical situation. So their major emphasis is, as it should be, on how the patient receives and benefits from the care, not how the instructor perceives the care - to be graded A,B,C or whatever.

Courtesy was described today as the common worth seen in a person so that we do not injure the person, but rather show up their good and not our ego. And if we are as the old poem says "interested in walking a mile in that person's shoes before we make any criticisms", then we are very careful about tearing down somebody before we build them up, because most of us really don't have any idea of what the other person is about unless we have been in that same situation. So faculty have been students, students have never been faculty, so therefore we have a gap that we can't close immediately.

I would like to conclude by saying that respect for the person and trust will go a long way in whatever relationship you have.

SUMMARY DISCUSSION
CAUCUS GROUPS

Leah L. Curtin, RN, MS, FAAN

As I understand my charge it is to draw together and interpret some of what has been said, to provide an opportunity for responses and feedback.

There has been overall agreement today on the desirability of trust and a willingness to take risks. I began my presentation this morning with a short quote, written over two hundred years ago, which said "It is better to be cheated sometimes than not to trust". That is the consensus of feeling that is evident today. However, I also have sensed a desire to make the concept of building trust relationships applicable in professional and institutional relationships. We have heard throughout the day a number of ways to do this. Essentially what we have heard is that mistrust often arises from misunderstanding, misinterpretation, and perhaps some honest disagreements about the way in which to accomplish mutual goals. Divergent views arise from such questions as: What should be the distribution of power? or, Who should make decisions about what or when? rather than any really deliberate dishonesty, intentional exploitation, or inappropriate manipulation of people.

Trust is a result of experiencing truth. In other words, the experience of having people actually do what they say they will do -- keeping their promises. This can be enhanced by sharing experiences and open communication, although occasionally there are some things better left unsaid, especially if one is angry. Honest communication and openness, are usually characteristics of people who are fair, consistent, respectful, and tolerant of differences. A credibility gap may occur as a result of people failing to see others delivering on promises they have made, or the obligations they have said they would fulfill. Whether the perception is actual or imaginary does not matter -- mistrust results.

Often we find ourselves in ambiguous situations as was clearly demonstrated by the person who spoke about faculty-student situations in which the authority of the teacher is uncertain. Do we dare to fail someone? What is the responsibility of the educator to the student, to the institution (where the money is), and to society (for producing a quality product)? Students may be promoted from year to year until their senior year, when a professor may confront the marginal student who should have been failed long before. This is not an easy thing; it creates mistrustful situations for both the faculty and the student.

In the practice setting as was discussed in one group in the process of evaluating staff, how objective can we be? What do you do with the marginal worker who has been kept on and on, so that it becomes very difficult to remove him /her? No one has the courage to say what should have been said earlier so that corrective action could have been taken earlier. In this kind of situation fear and ambiguity feed into mistrust.

The first step is to acknowledge the feelings and define the true nature of the problem, then proceed toward more positive relationships. At a practical level, this does not mean you must trust everyone you meet. Trust has levels. You can trust people to do certain things, for example, you may trust me to carry out the policies of my employing agency even if you do not like them. And I may be able to trust you to carry out policies based on my belief in your professional training, even though I may not know you. This does not mean I would automatically trust you under all circumstances. It may be realistic in our professional, and personal, and institutional relationships to say that we are adaptable. For example, I injured my knee when I was in an automobile accident a number of years ago and ever since that time I can trust that knee to go out whenever I play tennis. That does not mean I like it. It is a trustworthy knee though, it will go out everytime. I adapt to it and I adjust to it. We can use the same technique with people by adapting and adjusting. That does not mean we mistrust. If we can adapt and adjust then we can implement the strategies suggested by the various speakers in different ways. We can use persuasion, negotiation, mediation, compromise, and most particularly affirmation in our professional and institutional relationships with deliberate intent to promote trust.

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